Exhibit 4

SUMMARY PLAN DESCRIPTION

For

Providence Health Group, LLC.

MEDICAL PLAN

110 Glancy St. Suite 114
Goodlettsville, TN 37072

Effective Date: 12/01/2018

PLAN ADMINISTRATOR:
Providence Health Group, LLC.
110 Glancy St. Suite 114
Goodlettsville, TN 37072

CLAIMS ADMINISTRATOR:
Leading Edge Administrators
14 Wall Street, Suite 5B
New York, NY 10005
(888) 721-2128

Important: This is not an insured benefit plan. The benefits described in this Summary Plan Description (SPD) are funded by the Employer that is responsible for their payment. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims

This document is your Summary Plan Description ("SPD"). It describes in detail the benefits available to you under the self-funded health benefits program that has been established under the health plan identified above (the "Plan"). This SPD also sets forth other important information, including the rules of eligibility for benefits, when coverage terminates, the procedures to be followed when submitting a claim and grievance and appeal rights. The Schedule of Benefits, located in the Appendices of this document, has been established by the Plan Sponsor and is deemed a part of this SPD.

The Plan is designed to cover a part of your medical expenses; however, it may not cover your entire expenses. Before having any medical treatment, you should first discuss the charges with your doctor so that you know what portion of the bill you will be responsible for after the Plan and any other insurance reimbursements. All provisions of the Plan are subject to the rules, regulations or procedures in effect at the time of a claim.

Every effort has been made to accurately describe the Plan in this SPD. However, if the Plan is required to operate in a different manner to comply with federal laws and regulations, the appropriate federal laws and regulations will control.

Please read this SPD carefully so that you understand the terms and conditions of the Plan.

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SECTION 1
DEFINITIONS

The following definitions are used in this SPD:

Act of War: Any act pertaining to military, naval or air operations in time of War.

Active: Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Admission: Days of Inpatient services provided to a Covered Person.

Adverse Benefit Determination means any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational or Unproven or not Medically Necessary and Appropriate.

Affidavit of Domestic Partner/Statement of Domestic Partnership: A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership/ Statement of Domestic Partnership to the Plan Administrator is required prior to Domestic Partner coverage becoming effective.

Affordable Care Act (ACA) means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Alcoholism See "Substance Abuse/Substance Use Disorder" below.

Allowable Charge(s) - the Maximum Allowable Charge for any Medically Necessary and Appropriate, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Charges shall in no event exceed the Other Plan's Allowable Charges.
When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Ambulance Service is a medically necessary medical transportation provider, licensed by the state, which provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Approved Clinical Trial means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).
The Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").
A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Covered Person provides medical and scientific information establishing that their participation is appropriate.
"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out of network benefits are otherwise provided under the Plan.

Assignment of Benefits means an arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, Co-Payments and the Coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, Co-Payments and the Coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits previously issued to a Provider at its discretion and continue to treat the Covered Person as the sole beneficiary.

Child Dependent, A person who: has not attained the age of 26; and is:

a) The natural born child or stepchild of you or your Spouse;
b) A child who is: (a) legally adopted by you or your Spouse; or (b) placed with you for adoption. But, proof of such adoption or placement must be furnished to Claims Administrator upon request;
c) You or your Spouse's legal ward. Proof of guardianship must be furnished upon request.

Claims Administrator is the company the Plan Sponsor chose to administer claims. As of the date noted above, Leading Edge Administrators was chosen to administer the Plan.

Clean Claim is a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and

abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.
Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Clinical Eligibility for Coverage: Services required diagnosing or treating an injury or sickness. Services must be known to be safe, effective and appropriate by most qualified practitioners who are licensed to treat that injury or sickness. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the injury or sickness. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the qualified practitioner.
Any service or supply that does not meet the plan's guidelines for clinical eligibility for coverage is excluded from coverage

Coinsurance: The percent applied to Covered Expenses (not including Deductibles) for certain Covered Services or Supplies in order to calculate benefits under the Plan. These are shown in the Schedule of Covered Services and Supplies. The term does not include Co-Payments. Unless the context indicates otherwise, the Coinsurance percentages shown in this SPD are the percentages that member will pay.

Co-Payment or Co-Pay is that portion of eligible medical and prescription drug expenses for which you are financially responsible and are payable at the time services are rendered.

Covered Expense(s) a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary and Appropriate service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.
All treatment is subject to benefit payment maximums shown in the Schedule of Benefits, listed in Appendices A and B, and as set forth elsewhere in this document.

Covered Person is any Covered Person and his or her eligible Dependents when properly enrolled in the Plan as a new hire or during the open enrollment period as defined in Section 2, or following a qualifying event such a birth, marriage or adoption.

Covered Services and/or Supplies: The types of services and supplies described in the Covered Services and Supplies section of this SPD. Except as otherwise provided in this SPD, the services and supplies must be furnished or ordered by a Provider and for Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental Illness) or Injury.

Current Procedural Terminology (C.P.T.): The most recent edition of an annually revised listing published by the American Medical Association, which assigns numerical codes to medical procedures.

Custodial Care: Care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson who does not have professional qualifications or skills. Custodial Care includes, but is not limited to: help in walking or getting into or out of bed; help in bathing, dressing and eating; help in other functions of daily living of a similar nature; administration of or help in using or applying creams and ointments; routine administration of medical gasses after a regimen of therapy has been set up; routine care of a patient, including functions such as changes of dressings, diapers and protective sheets and periodic turning and positioning in bed; routine care and maintenance in connection with casts, braces and other similar devices, or other equipment and supplies used in treatment of a patient, such as colostomy and ileostomy bags and indwelling catheters; routine tracheostomy care; general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not need the skills of a therapist and are not skilled services.
Even if a Covered Person is in a Hospital or other recognized Facility, Plan does not cover care if it is custodial in nature.

Deductible is the amount of eligible medical or prescription drug expenses that you are responsible for paying each Plan year (the calendar year) before the Plan begins to pay benefits. Certain benefits are covered without the Deductible applying, as described on the Schedule of Benefits.
Deductible amounts accumulate separately for In and Out of Network.

Dentist is a person who is a doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.), licensed where required and performing services within the scope of such licensure.

Dependent under this Plan is:

- Your legal Spouse, as determined under federal law, other than a legally separated spouse;
- Your unmarried or married children up to age 26. Coverage will be terminated at the end of the month in which the child turns 26 years old. Please see the definition of "Child Dependent" above.

Grandchildren are not eligible for coverage. The baby will only be covered for the hospital stay provided the Plan does not specifically exclude maternity coverage for dependents in the Schedule of Benefits.

Detoxification Facility: A Facility licensed as a Detoxification Facility for the treatment of Alcoholism, or one that meets the same standards if located in another state.

Developmental Disability: A person's severe chronic disability which:

a. is attributable to a mental or physical impairment, or a combination of them;
b. for the purposes solely of the provision of this Plan entitled "Diagnosis and Treatment of Autism and Other Developmental Disabilities", is manifest before age 22;
c. is likely to continue indefinitely;
d. results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; the capacity for independent living or economic self-sufficiency; and
e. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

Developmental Disability includes, but is not limited to, severe disabilities attributable to: intellectual disability; autism; cerebral palsy; epilepsy; spina-bifida; and other neurological impairments where the above criteria are met.

Diagnostic Services: Procedures ordered by a recognized Provider because of specific symptoms to

diagnose a specific condition or disease. Some examples are:

a) radiology, ultrasound and nuclear medicine;
b) lab and pathology; and
c) EKG's, EEG's and other electronic diagnostic tests.

Durable Medical Equipment: Medically Necessary and Appropriate equipment which meets these requirements:

a) It is designed for and able to withstand repeated use;
b) It is primarily and customarily used to serve a medical purpose;
c) It is generally not useful to a person in the absence of an Illness or Injury; and
d) It is suitable for use in the home.

Some examples are: walkers; wheelchairs (manual or electric); hospital-type beds; breathing equipment; and apnea monitors.

Some examples of services and supplies that are not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all-terrain vehicles (ATVs); non-hospital-type beds; air conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency alert equipment; handrails; hearing aids, heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

Emergency Care is medical or dental care and treatment provided for any of the following:

- A medical condition that comes on suddenly and is manifested by symptoms of such severity, including severe pain, that a prudent person with average knowledge of medicine could reasonably expect that the absence of immediate medical attention could result in:
  - Placing the health of the afflicted person in serious jeopardy; or
  - Causing serious dysfunction of any bodily organ or part; or
  - Causing serious disfigurement of the afflicted person.
- Treatment and services due to a non-work-related accident and rendered within 48 hours of such accident.
- Treatment and services due to a sudden onset of serious illness and rendered within 24 hours of such illness.
- Emergency situations such as uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, serious burns or cuts, and broken bones.

Employee means an employee of Providence Health Group, LLC. or any of its subsidiaries and affiliates that have duly adopted Plan. The Plan is not available to any individuals classified by the Employer as an independent contractor, or an individual classified as an employee of a third party, even if such individual is retroactively classified as an employee of the Employer that adopted the Plan by any governmental agency, court or any other third-party.

Employer refers to Providence Health Group, LLC. or any of its subsidiaries and affiliates that have duly adopted the Plan.

Essential Health Benefits means, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription

Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of South Carolina as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Experimental Investigational or Unproven Services means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized by the Claims Administrator as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. The Claims Administrator will include the following items in this definition:

a. Items within that are the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services);
b. Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
c. Items based on anecdotal and unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy are not clearly established; or
d. Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes; or
e. Items for which approval required by the FDA has not been granted for marketing.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered experimental, investigational or unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.
The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental, Investigational or Unproven.

Explanation of Benefits (EOB)
"Explanation of Benefits" shall mean a statement a health plan sends to a Covered Person which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

Facility: An entity or institution which provides health care services within the scope of its license, as defined by applicable law.

FDA: The Food and Drug Administration.

Health Care Provider or Provider means a Hospital, ambulatory surgery facility, a diagnostic testing facility or a Physician.

Home Health Agency: A Provider which mainly provides care for an ill or injured person in the person's home under a home health care program designed to eliminate Hospital stays. To qualify, Agency must be licensed by the state in which it operates; or is certified to take part in Medicare as a Home Health Agency.

Home Health Care: Nursing and other Home Health Care services rendered to a Covered Person in his/her home. For Home Health Care to be covered, these rules apply:

a) The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.
b) Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.
c) The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

Hospice: A Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. To qualify, Provider must either be approved for its stated purpose by Medicare or accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospice Care Program: A health care program which provides an integrated set of services designed to provide Hospice care. Hospice services are centrally coordinated through an interdisciplinary team directed by a Practitioner.

Hospital means an accredited general or specialty hospital which is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services; Is supervised by a staff of Physicians; provides twenty-four (24) hour-a-day R.N. service; charges patients for its services; is operating in accordance with the laws of the jurisdiction in which it is located; or does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations. Care in institutions or parts of institutions principally used as clinics or maintained for care of the aged or chronically ill, rest or nursing homes, or other extended care facilities (such as acute and sub-acute rehabilitation) are not considered Hospitals within the meaning of the Plan.

Illness is any bodily sickness or disease, including any congenital abnormality as diagnosed by a Physician and as compared to the person's previous condition. Expenses Incurred because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any other Illness.

Incurred means any charge submitted to the Plan for medical services that is properly payable under the Plan. A charge is Incurred on the date on which the applicable service is performed, regardless of the date on which payment is required or rendered.

Inherited Metabolic Disease: A disease caused by an inherited abnormality of body chemistry for which testing is mandated

Injury is any damage to a body part resulting from trauma from an external source.

In-Network Provider is a Provider that has agreed to accept for the service or supply under a contractual agreement the Provider has with the network recognized by the Plan.

Inpatient is a registered bed patient in a Hospital for whom a room and board charge is made.

Joint Commission: The Joint Commission on the Accreditation of Health Care Organizations

Maintenance Therapy: That point in the therapeutic process at which no further improvement in the gaining or restoration of a function, reduction in disability or relief of pain is expected. Continuation of therapy at this point would be for the purpose of holding at a steady state or preventing deterioration.

Maximum Allowable Charge will be a negotiated rate, if one exists. In the absence of a negotiated rate, the Maximum Allowable Charge will be calculated by the Plan Administrator taking into the account any or all of the following:
An amount determined by the Claims Administrator as the least of the following amounts: (a) the actual charge made by the Provider for the service or supply; or (b) the amount determined by the Plan Administrator to be Usual and Customary, as defined herein.
Unless otherwise indicated on the Schedule of Benefits, no coverage is available for services performed by Providers or facilities that are not In-Network. In regard to the Schedule of Benefits:

The Schedule of Benefits may specify the type of network recognized by the Plan. If no such network is specified, please contact the Claims Administrator.
The Plan is not responsible for the balance of any Out of Network provider charge.
The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Appropriate and Reasonable service.

Medicaid: The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medical Care is professional medical services rendered by a licensed medical care provider for the treatment of an illness or injury.

Medical Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to: severe pain; psychiatric disturbances; and/or symptoms of Substance Abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:

a) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b) serious impairment to bodily functions; or
c) serious dysfunction of a bodily organ or part.

With respect to a pregnant woman who is having contractions, a Medical Emergency exists where: there is not enough time to make a safe transfer to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.
Examples of a Medical Emergency include but are not limited to: heart attacks; strokes; convulsions; severe burns; obvious bone fractures; wounds requiring sutures; poisoning; and loss of consciousness.

Medical Record Review is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Prescription Drug or supply was provided

which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medically Necessary and Appropriate (Medical Necessity and Appropriateness) is services or supplies provided by a licensed medical care provider that the Plan determines are:

a) appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury;
b) provided for the diagnosis or the direct care and treatment of the patient's condition, illness, disease or injury;
c) safe, effective and in accordance with standards of good medical practice;
d) not primarily for the convenience of the patient, the patient's family; or the qualified Provider;
e) performed in a cost-effective manner as compared to alternative interventions, including no intervention, where cost effective does not necessarily mean lowest cost, provided that the diagnosis or treatment of the applicable illness, injury or disease, the service is: (1) not costlier than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
f) not experimental or investigative; and
g) The most appropriate supply or level of service that can safely be provided to the patient. When applied to hospitalization, this further means that the patient requires acute care as an inpatient due to the nature of the services rendered or the patient's condition, and the patient cannot receive safe or adequate care as an outpatient.

Any service or supply that does not meet the Plan's guidelines for coverage is excluded from coverage. The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary and appropriate and does not guarantee payment. The Plan reserves the right to determine, in its sole judgment, whether a Service is medically necessary and appropriate. No benefits hereunder will be provided unless the Plan determines that the Service or supply is medically necessary and appropriate. Eligible expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Medicare is the Health Insurance Program for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as amended.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

a) The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).
b) The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use

disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Mental Illness is an emotional or mental disorder, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or Chemical Dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, Chemical Dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid Obesity is having a Body Mass Index (BMI) equal to or greater than 40. BMI is your weight in kilograms divided by your height in meters squared. Coverage is available for certain non-experimental and scientifically proven, surgical treatment by a qualified practitioner. Pre-authorization is required or benefits will not be payable under the plan. The plan reserves the right to determine whether the treatment is eligible for coverage. Benefits do not include nutritional supplements, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs.

Network or In-Network the facilities, Providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Covered Persons, and by whose terms the Network's Providers have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Covered Person's identification card.

Non-Covered Expenses: Charges for services and supplies which:

a) do not meet this Plan's definition of Covered Expenses;
b) exceed any of the coverage limits shown in this SPD; or
c) are specifically identified in this SPD as Non-Covered Expenses.

Nurse: A Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), or a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a) is properly licensed or certified to provide medical care under the laws of the state where he/she practices; and
b) provides medical services which are: (a) within the scope of his/her license or certificate; and (b) are covered by this Plan.

Other Plan shall include, but is not limited to:

a) Any primary payer besides the Plan.
b) Any other group health plan.
c) Any other coverage or policy covering the Covered Person.
d) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
e) Any policy of insurance from any insurance company or guarantor of a responsible party.
f) Any policy of insurance from any insurance company or guarantor of a third party.
g) Workers' compensation or other liability insurance company.
h) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Network Benefits: The coverage shown in the Schedule of Covered Services and Supplies which is provided if an Out-of-Network Provider provides the service.

Out-of-Hospital: Services or supplies provided to a Covered Person other than as an Inpatient or Outpatient.

Out-of-Network Provider is any provider of care who is not an In-Network provider.

Out-of-Pocket Maximum: The maximum dollar amount that a Covered Person must pay as Deductible, Co-Payments and/or Coinsurance for Covered Services and Supplies during any Benefit Period. Once a Deductible or Coinsurance maximum is reached, no further Deductible or Coinsurance is required for the remainder of that Benefit Period.
Out of Pocket amounts accumulate separately for In and Out of Network.

Outpatient is a Covered Person or any other Covered Person who receives medical care services or supplies while not an Inpatient.
Patient Protection and Affordable Care Act (PPACA) means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

Per Lifetime: During the lifetime of a person.

Pharmacy: A Facility: (a) which is registered as a Pharmacy with the appropriate state licensing agency; and (b) in which Prescription Drugs are dispensed by a pharmacist.

Physician is any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Prescription Drugs: Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing without a Prescription." The term includes: prescription female contraceptives; insulin; and may include other drugs and devices (e.g., syringes; glucometers; over-the-counter drugs mandated by law), as determined by Claims Administrator. For the purpose of this provision, "prescription female contraceptives" are drugs or devices, including, but not limited to, birth control pills and diaphragms, that: (i) are used for contraception by a female; (ii) are approved by the FDA for that purpose; and (iii) can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions.

Prior Authorization: Authorization for a Practitioner to provide specified treatment to Covered Persons.

Plan Administrator is Providence Health Group, LLC. or its delegate.

Plan Sponsor is the Employer named above.

Policy is a set of coverage rules as explained in this SPD which applies to Covered Persons, and any other Covered Persons. At no time will the Plan ever pay more than the established limits as determined by the Plan Administrator.

Preventive Care Services are the recommended preventive services identified by the federal Patient Protection and Affordable Care Act (PPACA). These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and Health Resources and Services Administration (HRSA) Guidelines, including the American Academy of Pediatrics Bright Futures periodicity guidelines. You may call Customer Service using the number on Your ID card for additional information about these services or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/

Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

Qualified Medical Child Support Order (QMCSO) creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies. A QMCSO will be recognized as "qualified" comply with applicable requirements of federal law.

Skilled Nursing Care: Services which: (a) are more intensive than Custodial Care; (b) are provided by an R.N. or L.P.N.; and (c) require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Facility: A Facility, which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. To qualify, facility must carry out its stated purpose under all relevant state and local laws and is either accredited for its stated purpose by the Joint Commission or approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

Special Care Unit: A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;
b) cardiac care units;
c) neonatal care units; and
d) burn units.

Spouse: The person who is legally married to the Employee. Proof of legal marriage must be submitted upon request.

Substance Abuse and/or Substance Use Disorder Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM)

definition of "Substance Use Disorder" is applied as outlined below.
A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

a) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).
b) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
c) Craving or a strong desire or urge to use a substance.
Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

The fact that a disorder is listed in the DSM does not mean that treatment of the disorder is covered by the Plan.

Substance Abuse Centers: Facilities that mainly provide treatment for people with Substance Abuse problems or Alcoholism. To qualify as a Substance Abuse Center, the facility must be accredited for its stated purpose by the Joint Commission or approved for its stated purpose by Medicare.

Surgery is any Medically Necessary and Appropriate operative or diagnostic procedure performed in the treatment of an Injury or illness by instrument or cutting procedure through an incision or any natural body opening.

Therapy Services: The following services and supplies when they are:

a. ordered by a Practitioner;
b. performed by a Provider;
c. for a Covered Person who is a Hospital Inpatient or Outpatient, or a recipient of care given by a Home Health Agency; and
d. Medically Necessary and Appropriate for the treatment of a Covered Person's Illness or Accidental Injury.

Chelation Therapy: The administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy: The treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy: Retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment: The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy: The administration of antibiotic, nutrient, or other therapeutic agents by direct infusion.

Occupational Therapy: The treatment to develop or restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy: The treatment by physical means to: relieve pain; develop or restore normal function; and prevent disability following Illness, Injury or loss of limb.

Radiation Therapy: The treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes the rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy: The introduction of dry or moist gases into the lungs.

Speech Therapy: Therapy that is by a qualified speech therapist and is described in a., b. or c:

a) Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (i) therapy to correct pre-speech deficiencies; and (ii) therapy to improve speech skills that have not fully developed.
b) Speech therapy to develop or improve speech to correct a defect that both existed at birth; and impaired or would have impaired the ability to speak.
c) Regardless of anything in a. or b. above to the contrary, speech therapy needed to treat a speech impairment of a Covered Person diagnosed with a Developmental Disability.

For the purposes of this Plan, "Speech Therapy" shall also be deemed to include feeding therapy, when Medically Necessary and Appropriate, designed to facilitate normal feeding patterns.

Total Disability or Totally Disabled: A disability that result from a bodily Injury or disease that wholly prevents the person from engaging in any gainful work as determined by the Plan Administrator.

Urgent Care: Outpatient and Out-of-Hospital medical care which is needed due to an unexpected Illness, Injury or other condition that is not life threatening, but that needs to be treated by a Provider within 24 hours.

Usual and Customary (U&C) means Covered Expenses which are identified by the Plan Administrator. The Usual and Customary amount for a given item of service or supply will typically be 140% of the Medicare Fee Schedule. If the Medicare Fee Schedule does not include a particular service, the reimbursement rate will be the 80th percentile of the Usual Customary and Reasonable ("UC&R") charges, using industry-standard data sources. If both the Medicare Fee Schedule does not include a particular service, and a UC&R charge is not available at the 85th percentile using industry-standard data sources, the service will be priced at 50% of billed charges. The Plan Administrator may, in its discretion, take into consideration any or all of the following, if the Plan Administrator deems it appropriate: the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply; the cost to the Provider for providing the services; and the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must follow generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

War: Includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

Work Related means an Injury or Illness arising out of or in the course of one's employment, whether or not the person properly asserts his or her rights and whether or not any recovery is received.

You or Your refers to the Covered Person, unless the context clearly indicates otherwise.

SECTION 2
ELIGIBILITY

ELIGIBLE EMPLOYEE

You become eligible when you are classified by your Employer as working 30 or more hours per week as a regular full-time Employee and satisfied the necessary waiting period, if any. The waiting period for new hires is completion of 60 days of employment. An Employee can enroll, effective as of the first of the month following the completion of the waiting period. Dependents may be enrolled as well at that time. An Eligible Employee is subject to the following conditions:

a. An Eligible Employee is a Salaried or Hourly Employee, and not an Employee classified as per diem, project rate, day rate or temporary.
b. If you are not hired into a full-time role, you will be notified if you meet the eligibility requirements during your initial measurement period.
c. Eligible Person does not include an Employee who is a member of a Union or otherwise covered by a Collective Bargaining Agreement, the subject of which does not provide for coverage under this Plan, even if the Employee would otherwise be considered an Eligible Person.

ELIGIBLE DEPENDENT

The following are the guidelines to determine an Eligible Dependent:

1. Unless otherwise set forth in this Section, coverage for a child Eligible Dependent who ceases to meet the definition of an Eligible Dependent due to age automatically terminates and all benefits hereunder cease, at the end of the month in which the Eligible Dependent ceases to be eligible.
2. A newborn child of the Covered Person will be covered for the first 48 hours after a vaginal delivery or for the first 96 hours after a cesarean delivery (coverage is limited to routine nursery care under the mother's benefit). Thereafter, the newborn will be covered only if the Participant enrolls the newborn child within 31 days of the birth and provides Plan Administrator with sufficient evidence to substantiate the eligibility of the newborn with official documents (such as birth certificate) and any required premium, coverage for the newborn child will be applied retroactively to the date of birth.
   Maternity Care for dependent daughters and a newborn child born to a child Eligible Dependent is not covered under the Plan.
3. An Employee or Dependent may also be eligible for coverage under the Plan if they are entitled to enroll for coverage under this benefit program pursuant to the special enrollment rights granted under the Health Insurance Portability and Accountability Act of 1996.
4. The Plan is Not available to domestic partners and civil union partners.

EFFECTIVE DATE

The Effective Date for when coverage begins for an Eligible Employee or any other Covered Person, as applicable, is the date specified by the Employer in writing and received by the Plan, unless an earlier Effective Date is required by law.

INITIAL ENROLLMENT

Once you become eligible you must enroll in the Plan if you want to receive benefits. You must enroll in the Plan within thirty (30) days of when you first become eligible. Obtain an Enrollment Form from your Employer and return the completed form immediately. If you do not, the start of your coverage will be delayed and you will not have an opportunity to enroll until the Plan's next open enrollment period.

For Dependent coverage, you must list your Eligible Dependents with their dates of birth and submit legal marriage, birth, or adoption certificates.
The Plan will deny claims for benefits Incurred before your Enrollment Form was received by the Claims Administrator, or for a Dependent not listed on the form.
It is your obligation to keep the Claims Administrator informed and to file for a new enrollment form within 30 days of any changes in:

- Address
- Dependent Status (Birth/Adoption of a Child)
- Marital Status

The Eligible Employee is responsible for providing the Claims Administrator with accurate and current enrollment information.

REQUESTS FOR INFORMATION

You are required to submit all documentation necessary to substantiate your eligibility or the eligibility of your Dependents whenever requested by the Claims Administrator. If you refuse or fail to furnish such documentation the Claims Administrator may deny eligibility or withdraw you and/or your Dependents from enrollment.

LATE ENROLLMENT

If you and/or your Eligible Dependents did not enroll during your eligibility period or any special enrollment periods described in this Section you will not be eligible for coverage until the next open enrollment period.

SPECIAL ENROLLMENT

This Plan provides special enrollment periods that allow you to enroll in the Plan, even if you declined enrollment during an initial or subsequent eligibility period.
If you declined enrollment for yourself or your dependents (including your spouse) because you had other health coverage, you may enroll for coverage for yourself and/or your dependents if the other health coverage is lost. You must complete a written application for special enrollment within thirty (30) days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Claims Administrator and apply for coverage by close of business on October 16.
If You are an Eligible Employee or Dependent and you lose your Medicaid or state Children's Health Insurance Program coverage, also called CHIP, you have sixty (60) days to elect coverage under the Plan.
You or your Eligible Dependents may enroll during this special enrollment period if the person who wishes to enroll, called the "enrollee," meets all of the following conditions:

- The enrollee is eligible for coverage under the terms of this Plan;
- The enrollee is not currently enrolled under the Plan;
- When enrollment was previously offered, the enrollee declined because of coverage under another group health plan or health insurance coverage. You or the enrollee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan, if required by the Plan Administrator; and
- The other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The enrollee is not eligible for this special enrollment right if:

- The other coverage was COBRA continuation coverage and the enrollee did not exhaust the maximum time available to you for that COBRA coverage; or

- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the enrollee will be effective as of the first of the month following the date of the event, assuming that information is provided in the allowable timeframe.

Special Enrollment for New Dependents

If you acquire a new dependent as a result of marriage, legal guardianship, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents during a special enrollment period. You must make written application for special enrollment no later than 30 days after you acquire the new Dependent, excluding the day of the acquisition. For example, if you are married on September 15, you must notify the Claims Administrator and apply for coverage by close of business on October 14.

You may enroll yourself and/or your eligible dependents during this special enrollment period if:

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new dependent through marriage, legal guardianship, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your dependent(s) will be effective at 12:01 a.m.:

- For a marriage, coverage will be effective as of the date of the marriage, assuming that information is provided in the allowable timeframe.
- For a legal guardianship, coverage will be effective on the date on which such Child Dependent is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child Dependent.
- For a birth, on the date of birth once receipt of proof of birth is received by the Plan.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption once receipt of proof of adoption is received by the Plan.

Cafeteria Plan Rules

Because this Plan is administered through a cafeteria plan arrangement in accordance with Section 125 regulations of the Internal Revenue Code, your premium contributions will be made on a pre-tax basis. Also, per this regulation, you are allowed to enroll or change coverage only during the annual open enrollment period. Exceptions are allowed if you experience a qualifying event and enroll or change your coverage due to the special enrollment rules.

Qualified Medical Child Support Orders (QMCSOs)

The Plan will provide coverage to your child if required to do so under the terms of a qualified medical child support order (referred to as a "QMCSO"). The Plan will provide coverage to a child under a QMCSO even if you do not have legal custody of the child, the child is not dependent on you for support, and the child does not reside with you and regardless of any waiting period that otherwise may exist for Dependent coverage. If the Plan receives a QMCSO and if you do not enroll the affected child, the Plan will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the Plan's procedures for determining whether an order is a QMCSO can be obtained from the Claims Administrator.

SECTION 3
TERMINATION OF BENEFITS

All benefit coverage for both you and your Dependents terminate as of the last day of employment, subject to the availability of COBRA continuation coverage, as described in Section 13 of this Summary Plan Description.
Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.
When your coverage ends, Your Employer will still pay claims for Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.
Your coverage under the Plan will end on the earliest of:

1. the last day of your employment with the Employer;
2. the date the Plan ends;
3. the last day of the month you stop making the required contributions;
4. the last day of the month you are no longer eligible. However, for a variable hour employee, coverage will continue until the end of the stability period, if he/she failed to qualify during the previous measurement period;
5. the last day of the month the Claims Administrator receives written notice from Your Employer to end your coverage, or the date requested in the notice, if later; or
6. the last day of the month you retire, unless specific coverage is available for retired persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

1. the date your coverage ends;
2. the last day of the month you stop making the required contributions;
3. the last day of the month the Claims Administrator receives written notice from Your Employer to end your coverage, or the date requested in the notice, if later; or
4. the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Continuing Health Care Benefits Handicapped Dependent Children
Coverage for your fully handicapped Dependent child may be continued past the maximum age for a Dependent child.

A dependent child age 26 and older is fully handicapped if he or she is who is unable to care for themselves because of physical or mental disability may be eligible for coverage beyond applicable age limits if the child is unmarried and physically or mentally incapable of self-care as determined by the Social Security Administration. The Claims Administrator requires appropriate documentation of such handicap for such continued coverage will have the right to require proof of the continuation of the handicap.
Proof that your child is fully handicapped must be submitted to the Claims Administrator no later than 30 days (or such later date established by the Plan) after the date your child reaches the maximum age under your Plan.
Continuation of coverage will cease on the first to occur of: Cessation of the handicap; failure to give proof that the handicap continues; termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your Plan.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as an Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the Affordable Care Act (ACA), with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Leave for Military Service under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")

If you are inducted into the Military Service of the Armed Forces of the United States of America, or if you enlist in the Military Service, including part-time National Guard Service, or if, because of membership in a reserve component of the Armed Forces, you are called into active federal service, your health coverage will be continued by the Plan during your first thirty-one (31) days of military service in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA") of 1994. After thirty-one (31) days, your eligibility for health care coverage under this Plan will be suspended during the period of your military service. You should receive military health care coverage at no cost. You may choose to continue coverage under this Plan, at your own expense up to a maximum of 24 months. You and your Dependents covered under the Plan may also be eligible to continue coverage under the COBRA provisions by making the required self-payments. The Plan does not voluntarily maintain your coverage; you and your Eligible Dependents will be given the opportunity to elect continuing coverage at your own expense.

If you are in the reserves and return from active duty you will be entitled to resume eligibility under this Plan if you return to active covered employment within ninety (90) days from the date of discharge, originally left the employer for military service from other than a temporary position and was released from active duty under "honorable conditions". The veterans' rights law requires this ninety (90) day grace period as a type of protection for Covered Persons, for the duration of the reserve call-up or any other type of military service up to five (5) years. The Plan is not obligated to offer this ninety (90) day period to Covered Persons serving in the military for five (5) or more years.

Essentially, the Plan will suspend your eligibility in the Plan until you are discharged. Your eligibility will be based on your hours worked in covered employment prior to entering the military. If you do not return to active covered employment within ninety (90) days (or any time otherwise specified), you will be considered a new employee, subject to the initial eligibility provisions.

Questions regarding your entitlement to this leave should be referred to your Employer. Questions about the USERRA continuation of coverage should be referred to the Plan Administrator.

May I continue to participate while I am absent under USERRA?

You may elect to continue coverage under the Plan for yourself and your dependents, when:

i. You and your dependents were Covered Persons in the Plan immediately prior to your leave of absence for uniformed service; and
ii. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

i. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to the Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;
ii. The cumulative length of this absence and all previous absences by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five year maximum requirement); and

iii. You comply with the notice requirements set forth under the question "When will coverage continued through USERRA terminate?"

The law requires the employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

i. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
ii. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees.

Continuation applies to all coverage provided under this Plan.

When will coverage continued through USERRA terminate?

Continued coverage under this provision will terminate on the earliest of the following events:

i. The date you fail to apply for or fail to return to work following completion of your leave. You must notify Employer of your intent to return to employment within:
   - For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:
     - Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
     - If reporting with such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.
   - For leaves of 30 to 180 days, by submitting an application to Employer for reemployment:
     - Not later than 14 days after completing uniformed service; or
     - If submitting such application within that period is impossible or unreasonable through no fault of your own, then the next first full calendar day when submission of such application becomes possible.
   - For leaves of more than 180 days, by submitting an application for reemployment not later than 90 days after completing uniformed service.
   - If you are hospitalized for, or convalescing from, an illness or injury Incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.
ii. The date you fail to pay any required contribution.
iii. 24 months from the date your leave began.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you

comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been Incurred in, or aggravated during, performance of your service in the uniformed services.

Family and/or Medical Leave

The Family and Medical Leave Act ("FMLA") is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible employee may elect to continue coverage under this Plan during a period of approved FMLA leave at the same cost as if the FMLA leave not been taken. The law provides eligible Employees with up to 12 weeks of job-protected, unpaid leave during any 12-month period for one or more of the reasons described below, so long as you have worked 1,250 hours during the preceding 12 months.

The FMLA also requires the Employer to maintain your coverage under the Plan during your period of leave under the FMLA just as if you were in Employment. Except as otherwise specified in your Employer's written leave policies, your coverage under the FMLA will cease once the Plan is notified or otherwise determines that you have terminated Employment, exhausted your 12 week FMLA leave entitlement, informed the Plan of your intent not to return from leave, or your Employer ceases to make contributions to the Plan on your behalf during the period of FMLA leave.

Once the Plan is notified or otherwise determines that you are not returning to Employment following a period of FMLA leave, you may elect continued coverage under the COBRA continuation of coverage rules. The Qualifying Event entitling you to COBRA coverage is the last day of your FMLA leave.

If you fail to return to Employment following your leave, your Employer may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition that affects you or a Family Member and that would normally qualify you for leave under the FMLA.

If provisions under the Plan change while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave from employment.

FMLA leave may be paid (using accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. The Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

Please refer to your Employer's written policies for rules and definitions governing application of FMLA for a covered employee.

All benefits coverage ends immediately if the Plan is terminated.

SECTION 4
MEDICAL BENEFITS

If a benefit is covered under this Plan and you are eligible for this benefit, the Plan will pay no more than the Allowable Charge. If the Services of an Out-of-Network Provider are payable under this Plan, they may request more than the Allowable Charge. In that case, you are responsible for the additional amount over what the Plan pays. Whenever possible, discuss the situation with the Provider in advance so that you will have an idea what you might have to pay.

BALANCE BILLING

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Non-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for any applicable payment of Coinsurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Appropriate and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

PRE-AUTHORIZATION PROVISION

Pre-Authorization may be necessary for the Plan to evaluate the proposed treatments or services for clinical eligibility for coverage before they are rendered. Hospital services, medical services, second surgical opinions and pre-determination of benefits, as explained below, all require Pre-Authorization.

In general, your Provider needs to initiate the approval process by calling the Claims Administrator before services are rendered. You will receive notification by telephone or in writing no more than three (3) business days after all necessary medical information is received.

To notify the Plan of an admission to a Hospital, the Provider must contact the Claims Administrator as follows:

i. At least three (3) days prior to the date of admission for elective procedures; and
ii. Within two (2) business days after an emergency admission;

The following services require Preauthorization, or benefit will be reduced to 50% of the allowed:

Inpatient Services:	Outpatient Services:
Acute Care	**Cochlear Implants**: Osseo integrated, cochlear or auditory brain stem implant
Maternity routine and high-risk (routine only if inpatient stay exceeds 48/96 federal requirements)	**Diagnostic Radiology**: CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms
Skilled Nursing Facility	**Durable Medical Equipment**: Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, miscellaneous DME
Rehabilitation	**Erectile Dysfunction**
Detox	**Gastric Bypass**
IP Mental Health and Substance Abuse-Hospital	**Home Health Care**
	Home Infusion Therapy
IP Mental Health and Substance Abuse-Residential	**Injectable Medications**
	Oral Pharynx Procedures
	Orthotics and Prosthetics
	Outpatient Procedures: Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty, Vascular surgery
	Potential experimental/investigational procedures
	Sleep Management Program
	Speech Therapy
	Spinal Procedures
	Therapeutic Radiology
	Transplants *Required opt in with Cigna Life Source Transplant Network*

The following information must always be provided to the Plan to satisfy the Pre-Authorization requirement. The Plan may also require additional information.

- Covered Person's and Patient's information: Name, Relationship to the Covered Person, Date of Birth and Address.
- Provider's information: Provider ID number, Tax ID number, Diagnosis code and Procedure code.

Your Network Provider is responsible for obtaining any required Preauthorization. However, the Plan recommends that you call Customer Service to ensure that your services have been Preauthorized.
Failure to notify for all services that require Pre-Authorization will cause the Plan to reduce the benefit payout by 50%.

Please remember: Any Preauthorization you receive will not be valid if your coverage under the Plan terminates. This means that Covered Services received after your coverage has terminated will not be Covered even if they were Preauthorized.

Additionally, Preauthorization is not a guarantee of benefits. The Plan reserves the right to review the Medical Necessity of any services you receive.

Note that if you are eligible for COBRA and make your COBRA election later than the first day of the coverage period to which it applies, but before the end of the election period for the COBRA coverage period, your coverage will be suspended as of the first day of the COBRA coverage period and then retroactively reinstated (going back to the first day of the COBRA coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended (including pre-service claims) may be denied and may have to be resubmitted once your coverage is reinstated.

COVERED BENEFITS AND SERVICES

A. ALCOHOLISM

The Plan covers the treatment of Alcoholism the same way it would any other Illness, if the treatment is prescribed by a Practitioner.

Inpatient or Outpatient treatment may be furnished as follows:

- Care in a licensed Health Care Facility
- At a Detoxification Facility; or
- As an Inpatient or Outpatient at a licensed, certified or State approved residential treatment Facility, under a program which meets minimum standards of care equivalent to those prescribed by the Joint Commission.

Treatment or a stay at any Facility shall not prevent further or additional treatment at any other eligible Facility, if the Benefit Days used do not exceed the total number of Benefit Days provided for any other Illness under the Plan.

B. ALLERGY TESTING

The Plan covers allergy testing and treatment, including routine allergy injections and immunizations, but not if solely for the purpose of travel or as a requirement of a Covered Person's employment.

C. AMBULANCE SERVICE

1. Ambulance Service means you are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
   a. For ground ambulance, you are taken: from your home, the scene of an accident or medical Emergency to a Hospital; between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or between a Hospital and a Skilled Nursing Facility or other approved Facility.
   b. For air or water ambulance, you are taken: from the scene of an accident or medical Emergency to a Hospital; between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital; or between a Hospital and an approved Facility.
2. Ambulance services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

3. Non-Emergency ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

D. AUDIOLOGY

The Plan covers audiology services rendered by a physician or licensed audiologist or licensed speech-language pathologist.

The services must be:

1. Determined to be Medically Necessary and Appropriate; and
2. Performed within the scope of the Practitioner's practice.

E. BLOOD

The Plan covers: (a) blood; (b) blood products; (c) blood transfusions; and (d) the cost of testing and processing blood. The Plan does not pay for blood that has been donated or replaced on behalf of the Covered Person.

Blood transfusions (including the cost of blood plasma and blood plasma expanders) are covered from the first pint. But, this is so only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

The Plan also covers expenses Incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia. The home treatment program must be under the supervision of a State approved hemophilia treatment center. A home treatment program will not preclude further or additional treatment or care at an eligible Facility.

As used above: (a) "blood product" includes but is not limited to Factor VIII, Factor IX and cryoprecipitate; and (b) "blood infusion equipment" includes but is not limited to syringes and needles.

G. DENTAL SERVICES

The Plan covers the following Dental Services:

- the diagnosis and treatment of oral tumors and cysts; and
- the surgical removal of bony impacted teeth; and
- Surgical and non-Surgical treatment of Temporomandibular joint dysfunction syndrome (TMJ) in a Covered Person. But, this Plan does not cover charges for orthodontia, crowns or bridgework. "Surgery", if needed, includes the pre- operative and post-operative care connected with it.

The plan also covers Dental Services rendered by a Physician or Dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth, or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

For a Covered Person who is severely disabled or who is a Child Dependent under age six, coverage shall also be provided for the following:

- General anesthesia and Hospital Admission for dental services; or
- Dental services rendered by a dentist, regardless of where the dental services are rendered, for medical conditions that: (a) are covered by this Plan; and (b) require a Hospital Admission for general anesthesia.

H. DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES

This Plan provides coverage for charges for the screening and diagnosis of autism and other Developmental Disabilities.

If a Covered Person's primary diagnosis is autism or another Developmental Disability, and regardless of anything in the Plan to the contrary, the Plan provides coverage for the following Medically Necessary and Appropriate Therapy Services, as prescribed in a treatment plan:

a. Occupational Therapy needed to develop the Covered Person's ability to perform the ordinary tasks of daily living;
b. Physical Therapy needed to develop the Covered Person's physical functions; and c. Speech Therapy needed to treat the Covered Person's speech impairment.

Notwithstanding anything in the Plan to the contrary, the foregoing Therapy Services as prescribed in a treatment plan will not be subject to benefit visit maximums.

Also, if a Covered Person's primary diagnosis is autism, in addition to coverage for certain Therapy Services, as described above, the Plan also covers Medically Necessary and Appropriate: (a) Behavioral Interventions Based on Applied Behavioral Analysis (ABA); and (b) Related Structured Behavioral Programs. Such interventions and programs must be prescribed in a treatment plan.

Benefits for these services are payable on the same basis as for other conditions, and they are available under this provision whether or not the services are restorative. Benefits for the above Therapy Services available pursuant to this provision are payable separately from those payable for other conditions and will not operate to reduce the Therapy Services benefits available under the Plan for those other conditions.

Any treatment plan referred to above must: (a) be in writing; (b) be signed by the treating Practitioner; and (c) include: (i) a diagnosis; (ii) proposed treatment by type, frequency and duration; (iii) the anticipated outcomes stated as goals; and (iv) the frequency by which the treatment plan will be updated. With respect to the covered behavioral interventions and programs mentioned above, the term "Practitioner" shall also include a person who is credentialed by the national Analyst Certification Board as either: (a) a Board-Certified Behavior Analyst-Doctoral; or (b) a Board-Certified Behavior Analyst.

I. DIABETES TREATMENT

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by an authorized Physician:

a. **Equipment and Supplies**
Blood glucose monitors, monitor supplies and insulin infusion devices.

2. **Diabetes Education Program**
When the Covered Person's or Eligible Dependent's Physician certifies that the Covered Person or Eligible Dependent requires diabetes education as an Outpatient, coverage is provided for the following when rendered through a Diabetes Education Program:
   a. Visits Medically Necessary and Appropriate upon the diagnosis of diabetes; and
   b. Subsequent Visits under circumstances whereby a Covered Person's or Eligible Dependent's Physician:
      i. Identifies or diagnoses a significant change in the Covered Person's or Eligible Dependent's symptoms or conditions that necessitates changes in a Covered Person's or Eligible Dependent's self-management, or
      ii. Identifies as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the Covered Person's or Eligible Dependent's treatment and/or management of diabetes.

J. **DIAGNOSTIC SERVICES**

Benefits will be provided for the following Covered Services only when such Covered Services are ordered by a Professional Provider:

a. Diagnostic X-ray consisting of radiology, magnetic resonance imaging (MRI, ultrasound and nuclear medicine);
2. Diagnostic pathology, consisting of laboratory and pathology tests;
3. Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by the Plan; and
4. Allergy testing, consisting of percutaneous, intracutaneous, and patch tests.

K. DURABLE MEDICAL EQUIPMENT

The rental (but not to exceed total cost of purchase) or, at the option of the Plan, the purchase, adjustment, repairs and replacement of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use.

L. EMERGENCY MEDICAL SERVICES

a. Medical Care for the emergency treatment of bodily injuries resulting from an accident.
b. Medical Care for the treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention.

M. ENTERAL FORMULAE

Coverage is provided for Enteral Formulae when administered on an Outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Additional coverage for Enteral Formulae is provided when administered on an Outpatient basis, when Medically Necessary and Appropriate for the Covered Person's or Eligible Dependent's medical condition, when considered to be the Covered Person's or Eligible Dependent's sole source of nutrition and when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or when provided orally and identified as one (1) of the following types of defined formulae:

a. with hydrolyzed (pre-digested) protein or amino acids; or
b. with specialized content for special metabolic needs; or
c. with modular components; or
d. with standardized nutrients

Once it is determined that the Covered Person or Eligible Dependent meets the above criteria, coverage for Enteral Formulae will continue as long as it represents at least fifty percent (50%) of the Covered Person's or Eligible Dependent's daily caloric requirement.

Coverage for Enteral Formulae excludes the following:

1. Blenderized food, baby food, or regular shelf food when used with an enteral system;
2. milk or soy-based infant formulae with intact proteins;
3. any formulae, when used for the convenience of the Covered Person or Eligible Dependent or their family member;
4. nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;

5. semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally; and
6. Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

N. FERTILITY SERVICES/ BASIC DIAGNOSTICS

Plan covers basic diagnostic infertility services to determine the cause of infertility. All coverage is subject to the terms and conditions of the plan.

A Person is considered infertile if he or she is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is over age 35 years. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women aged 35 or older up to age 44). (N.Y. Ins. Law §§ 3216(13), 3221(6), and 4303))

***Note**: coverage is provided for women up to age 44.*

Exclusion: infertility services for couples in which either of the partners has had a previous sterilization procedure, with or without surgical reversal, and for females who have undergone a hysterectomy.

Basic Infertility Services / Diagnostic Services

Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

The following services are considered medically necessary for diagnosis of infertility in females.

A. History and physical examination, basal body temperature

B. Laboratory studies:

1. Anti-adrenal antibodies for apparently spontaneous primary ovarian insufficiency (premature ovarian failure)
2. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
3. Chlamydia trachomatis screening)
4. Fasting and 2 hours post 75-gram glucose challenge levels
5. Lipid panel (total cholesterol, HDL cholesterol, triglycerides)
6. Post-coital testing (PCT) (Simms-Huhner test) of cervical mucus
7. Rubella serology
8. Testing for viral status (HIV, hepatitis B, hepatitis C)
9. Serum hormone levels
    a. Androgens (testosterone, androstenedione, dehydroepiandrosterone sulfate (DHEA-S) if there is evidence of hyperandrogenism (e.g., hirsuitism, acne, signs of virilization) or ovulatory dysfunction
    b. Anti-mullerian hormone (AMH), for the following indications: a) assessing menopausal status, including premature ovarian failure; b) assessing ovarian status, including ovarian reserve and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization.
    c. Gonadotropins (serum follicle-stimuating hormone [FSH], luteinizing hormone [LH]) for women with irregular menstrual cycles
    d. Prolactin for women with an ovulatory disorder, galactorrhea, or a pituitary tumor
    e. Progestins (progesterone, 17-hydroxyprogesterone) (see Appendix for medical necessity limitations)
    f. Estrogens (estradiol)

g. Thyroid stimulating hormone (TSH) for women with symptoms of thyroid disease
h. Adrenocortitrophic hormone (ACTH) for ruling out Cushing's syndrome or Addison's disease in women who are amenorrheic
i. Clomiphene citrate challenge test

10. Karyotype testing for couples with recurrent pregnancy loss (2 or more consecutive spontaneous abortions)

C. Diagnostic procedures:

1. CT or MR imaging of sella turcica is considered medically necessary if prolactin is elevated
2. Endometrial biopsy
3. Hysterosalpingography (hysterosalpingogram (HSG)) or hysterosalpingo-contrast-ultrasonography to screen for tubal occlusion. *Note: Sonohysterosalpingography or saline hysterosalpingography (e.g., Femvue) are considered experimental and investigational to screen for tubal occlusion because of a lack of reliable evidence of effectiveness.*
4. Hysteroscopy, salpingoscopy (falloscopy), hydrotubation where clinically indicated
5. Laparoscopy and chromotubation (contrast dye) to assess tubal and other pelvic pathology, and to follow-up on hysterosalpingography abnormalities
6. Sonohysterography to evaluate the uterus
7. Ultrasound (e.g., ovarian, transvaginal, pelvic)
8. Monitoring of ovarian response to ovulatory stimulants:
   a. Estradiol
   b. FSH
   c. hCG quantitative
   d. LH assay
   e. Progesterone
   f. Serial ovarian ultrasounds are considered medically necessary for cycle monitoring.

The following services are considered medically necessary for diagnosis of infertility in males.

A. History and physical examination
B. Laboratory studies:

1. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
2. Cultures
   a. Prostatic secretion
   b. Semen
   c. Urine
3. Serum hormone levels
   a. 17-hydroxyprogesterone
   b. Adrenal cortical stimulating hormone (ACTH)
   c. Androgens (testosterone, free testosterone) - if initial testosterone level is low, a repeat measurement of total and free testosterone as well as serum luteinizing hormone (LH) and prolactin levels is medically necessary
   d. Estrogens (e.g., estradiol, estrone)
   e. Gonadotropins (FSH, LH)
   f. Growth hormone (GH)
   g. Prolactin for men with reduced sperm counts, galactorrhea, or pituitary tumors
   h. Sex hormone binding globulin (SHGB) for men with signs and symptoms of hypogonadism and low normal testosterone levels. (SHGB is not indicated in the routine evaluation of male infertility)
   i. Thyroid stimulating hormone (TSH) for men with symptoms of thyroid disease.

4. Semen analysis (volume, pH, liquefaction time, sperm concentration, total sperm number, motility (forward progression), motile sperm per ejaculate, vitality, round cell differentiation (white cells versus germinal), morphology, viscosity, agglutination) is considered medically necessary for the evaluation of infertility in men. Because of the marked inherent variability of semen analyses, an abnormal result should be confirmed by at least one additional sample collected one or more weeks after the first sample.
   - For men with abnormal semen analysis exposed to gonadotoxins, up to 4 semen analyses are considered medically necessary.
   - For men with a normal initial semen analysis, a repeat semen analysis is considered medically necessary if there is no pregnancy 4 months after the initial normal semen analysis.
   - If the result of the first semen analysis is abnormal and the man has not been exposed to gonadotoxins, up to 2 repeat confirmatory tests may be considered medically necessary.
5. Vasography
6. Semen leukocyte analysis (e.g., Endtz test, immunohistochemical staining)
7. Seminal fructose
   Note: Seminal alpha-glucosidase, zinc, citric acid, and acid phosphatase are considered experimental and investigational.
8. Blood test for cytogenetic analysis (karyotype and FISH) in men with severe deficits of semen quality or azoospermia (for consideration of ICSI)
9. Cystic fibrosis mutation testing in men with congenital absence of vas deferens
10. Y chromosome microdeletion analysis in men with severe deficits of semen quality or azoospermia (for consideration of ICSI).
    Note: Y chromosome microdeletion analysis is not routinely indicated before ICSI, and is subject to medical necessity review
11. Post-coital test (PCT) (Simms-Huhner test) of cervical mucus
12. Sperm function tests including Sperm penetration assay (zona-free hamster egg penetration test)

O. HEARING AIDS

The Plan covers expenses Incurred for or in connection with the purchase of a hearing aid or hearing aids that have been prescribed or recommended by a Practitioner for a Child Dependent who is 18 years of age or younger once in every 36 months.

For a Child Dependent who is 18 years of age or younger and for whom a Practitioner has recommended a hearing aid, such expenses include, but are not limited to, charges Incurred for the following:

- the purchase of the hearing aid;
- hearing tests;
- fittings;
- modifications; and
- repairs (but not battery replacement).

All such services shall be deemed to be Basic Services and Supplies.

P. HOME HEALTH CARE/HOSPICE CARE SERVICES

a. Services rendered by a Home Health Care Agency or a Hospital program for Home Health Care and Hospice Care for which benefits are available as follows:
   i. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding Private Duty Nursing Services;

ii. Physical Medicine, Speech Therapy and Occupational Therapy Services
iii. Medical and surgical supplies provided by the Home Health Care Agency or Hospital Program for Home Health Care and Hospice Care;
iv. oxygen and its administration;
v. medical social service consultations;
vi. health aide services for a Covered Person or Eligible Dependent who is receiving covered nursing Services or Therapy and Rehabilitation Services;
vii. Family Counseling related to the Covered Person's or Eligible Dependent's terminal condition.

b. No Home Health Care/Hospice Care benefits will be provided for:
i. Dietitian services;
ii. Homemaker services;
iii. Maintenance therapy;
iv. Dialysis treatment;
v. Custodial Care; and
vi. Food or home delivered meals.

Q. HOME INFUSION THERAPY SERVICES

Benefits will be provided when performed by a licensed Home Infusion Therapy Provider in a home setting. This benefit includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Home Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Home Infusion Therapy.

R. HOSPITAL SERVICES

1. Services and supplies including, but not restricted to:
   a. use of operating, delivery and treatment rooms and equipment;
   b. drugs and medicines provided to a Covered Person or Eligible Dependent who is an Inpatient in a Facility Provider;
   c. whole blood, administration of blood, blood processing, and blood derivatives;
   d. Anesthesia, Anesthesia supplies and Services rendered in a Facility Provider by an employee of the Facility Provider, and the administration of Anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at Surgery;
   e. medical and surgical dressings, supplies, casts, and splints;
   f. Diagnostic Services; or
   g. Therapy and Rehabilitation Services.
2. **Bed and Board**

   Bed, board and general nursing Services in a Facility Provider when the Covered Person or Eligible Dependent occupies:
   a. a room with two (2) or more beds; or
   b. a private room or
   c. A bed in a Special Care Unit -- a designated unit which has concentrated all facilities, equipment, and supportive Services for the provision of an intensive level of care for critically ill patients.
3. **Emergency Accident Care**

   Services and supplies for the Outpatient emergency treatment of bodily injuries resulting from an accident.

4. **Emergency Medical Care**
   Services and supplies for the Outpatient emergency treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention.
5. **Pre-Admission Testing**
   Tests and studies required in connection with the Covered Person's or Eligible Dependent's admission rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.
6. **Surgery**
   Hospital Services and supplies for Outpatient Surgery including removal of sutures, Anesthesia, Anesthesia supplies and Services rendered by an employee of the Facility Provider other than the surgeon or assistant at Surgery.
7. **Inpatient Medical Services**
   a) Medical Care by a licensed Health Care Provider to a Covered Person or Eligible Dependent who is an Inpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided.
   b) Medical Care rendered concurrently with Surgery during one (1) Inpatient stay by a licensed Health Care Provider other than the operating surgeon for treatment of a medical condition separate from the condition for which Surgery was performed.
   c) Medical Care by two (2) or more licensed Health Care Providers rendered concurrently during an Inpatient stay when the nature or severity of the Covered Person's or Eligible Dependent's condition requires the skills of separate Physicians.
   d) Consultation Services rendered to an Inpatient by another licensed Health Care Provider at the request of the attending licensed Health Care Provider. Consultation does not include staff consultations which are required by the Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant per admission.
   e) Medical Care rendered to a Covered Person and Eligible Dependent whose condition requires a licensed Health Care Provider's constant attendance and treatment for a prolonged period of time.
   f) Licensed Health Care Provider Visits to examine the newborn infant.

Q. INHERITED METABOLIC DISEASE

The Plan provides benefits for the therapeutic treatment of Inherited Metabolic Diseases. This coverage includes the purchase of Medical Foods and Low Protein Modified Food Products that are determined to be Medically Necessary and Appropriate by the Covered Person's physician.
This Plan covers Specialized Non-Standard infant formulas, if these conditions are met:

a. The covered infant's physician has diagnosed him/her as having multiple food protein intolerance;
b. The physician has determined that the formula is Medically Necessary and Appropriate; and
c. The infant has not responded to trials of standard non-cow milk-based formulas, including soybean and goat milk.

R. MATERNITY SERVICES

Hospital Services and Medical/Surgical Services rendered by a Facility Provider or a licensed Health Care:

1. **Complications of Pregnancy**

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

2. **Maternity Home Health Care Visit**
   Benefits for one (1) maternity home Visit will be provided at the Covered Person's or Eligible Dependent's home within forty-eight (48) hours of discharge when the discharge from a Facility Provider occurs prior to:
   a) Forty-eight (48) hours of Inpatient care following a normal vaginal delivery, or
   b) Ninety-six (96) hours of Inpatient care following a cesarean delivery.
   This Visit shall be made by an In-Network Provider whose scope of practice includes postpartum care. The Visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The Visit may, at the mother's sole discretion, occur at the office of the In-Network Provider. The Visit is subject to all the terms of the Plan and is exempt from any Copayment, Coinsurance or Deductible amounts.
3. **Normal Pregnancy**
   Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.
4. **Newborn Care**
   Care for newborns includes preventive health care services (including electrophysiological screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. The Plan also covers, within the limits of this SPD, necessary transportation costs from the place of birth to the nearest specialized treatment center.

S. MENTAL HEALTH CARE SERVICES

1. Hospital Services are provided for the Inpatient treatment of Mental Illness by a Facility Provider.
2. The following Services are covered for the Inpatient treatment of Mental Illness when rendered by a licensed, mental Health Care Provider:
   - individual psychotherapy;
   - group psychotherapy;
   - psychological testing;
   - Family Counseling – Counseling with family members to assist in the patient's diagnosis and treatment, and
   - Convulsive therapy treatment. Electroshock treatment or convulsive drug therapy including Anesthesia when administered concurrently with the treatment by the same licensed, mental Health Care Provider.
3. Partial Hospitalization Mental Health Care Services
   Benefits are only available for partial hospitalization Mental Health Care Services provided by a partial hospitalization program which has been approved by the Plan and is offered by a Facility Provider or a licensed, mental Health Care Provider. Such programs are subject to periodic review by the Plan.
4. Outpatient Mental Health Care Services
   Medical Services Benefits as described in this Subsection are also available when provided for the Outpatient treatment of Mental Illness by a Facility Provider, or a licensed, mental Health Care Provider.

5. Mental Health Parity and Addiction Equity Act

Benefits under this Plan are subject to The Mental Health Parity and Addiction Equity Act, which provides for parity in the application of aggregate lifetime limits, annual dollar limits, and treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set annual dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than any such dollar limits or day/visit limits for medical and surgical benefits. A plan that does not impose annual dollar limits, lifetime dollar limits, or day/visit limits on medical and surgical benefits may not impose such dollar limits or day/visit limits on mental health and substance abuse benefits offered under the plan. Also, the plan may not impose deductibles, copayment/coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than deductibles, copayment/coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

T. NUTRITIONAL COUNSELING

The Plan covers charges for nutritional counseling for the management of a medical condition that has specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner. This section does not apply to nutritional counseling related to "Diabetes Benefits".

U. ORTHOTIC DEVICES

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part

V. OUTPATIENT MEDICAL CARE SERVICES

1. Medical Care rendered by a licensed Health Care Provider to a Covered Person or Eligible Dependent who is an Outpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specifically provided.
2. Medical Care Visits and consultation for the examination, diagnosis and treatment of an injury or illness.

W. PEDIATRIC EXTENDED CARE SERVICES

1. Services rendered by a Pediatric Extended Care Facility pursuant to a treatment plan for which benefits may include one (1) or more of the following:
   a. Skilled Nursing Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN);
   b. Physical Medicine, Speech Therapy and Occupational Therapy Services;
   c. Respiratory Medicine, Speech Therapy and Occupational Therapy Services;
   d. Medical and surgical supplies provided by the Pediatric Extended Care Facility;
   e. Acute health care support; and
   f. Ongoing assessments of health status, growth and development.
2. Pediatric Extended Care Services will be covered for children eight (8) years of age or under, (except where the Affordable Care Act requires the Plan to cover certain preventive services, such as health assessments, until up to 19 years of age) pursuant to the attending Physician's treatment plan only when provided in a Pediatric Extended Care Facility and when approved by the Plan;
3. A prescription from the child's attending Physician is necessary for admission to a Pediatric Extended Care Facility; and

4. No benefits are payable after the Covered Person or Eligible Dependent has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

X. PREVENTIVE CARE SERVICES

Benefits will be provided for covered services in accordance with Healthcare Reform mandates, including the following:

1. **Adult Care** - Benefits are provided for routine physical examinations, regardless of Medical Necessity, including a complete medical history, in accordance with a predefined schedule based on age and sex.
2. **Adult Immunizations** - Covered Persons and Eligible Dependents eighteen (18) years of age and older.
3. **Allergy Extract/Injections**
4. **Mammographic Screening**
   a. An annual routine mammographic screening for all female Covered Persons and Eligible Dependents forty (40) years of age or older.
   b. Mammographic examination for all female Covered Persons and Eligible Dependents regardless of age when such services are prescribed by a Physician.
5. **Pediatric Care** - Benefits are provided for routine physical examinations, regardless of Medical Necessity.
6. **Pediatric Immunizations**
   Coverage will be provided to Covered Persons and Eligible Dependents less than twenty-one (21) years of age and covered dependent children for mandated pediatric immunizations. Benefits are exempt from Deductibles or dollar limits.
7. **Routine Gynecological Examination and Papanicolaou Smear**
   Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou Smear per calendar year for all female Covered Persons and Eligible Dependents. Benefits are exempt from all Deductibles or Maximums.
8. **Colorectal Cancer Screenings**
   i) Diagnostic pathology and laboratory screening services such as fecal-occult blood or fecal immunochemical test;
   ii) Diagnostic x-ray screening services such as barium enema;
   iii) Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services; and
   iv) Such other diagnostic pathology and laboratory, diagnostic x-ray, surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer.
   v) For all Covered Persons and Eligible Dependents beginning at age fifty (50) as follows:
      - An annual fecal-occult blood test or fecal immunochemical test
      - A sigmoidoscopy every five (5) years
      - A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five (5) years
      - A colonoscopy every ten (10) years or more frequently than set forth above and regardless of age when prescribed by a Physician.
   vi) For Covered Persons and Eligible Dependents determined to be at high or increased risk, regardless of age.

Y. PROSTHETIC APPLIANCES

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Z. ROUTINE PATIENT COSTS FOR PARTICIPATION IN AN APPROVED CLINICAL TRIAL.

Charges for any Medically Necessary and Appropriate services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:
    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
    b. The National Institute of Health.
    c. The U.S. Food and Drug Administration.
    d. The U.S. Department of Defense.
    e. The U.S. Department of Veterans Affairs.
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2. The research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Charge, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial.

AA. SKILLED NURSING FACILITY SERVICES

1. Services rendered in a Skilled Nursing Facility to the same extent benefits are available to an Inpatient of a Hospital. Benefits for Skilled Nursing Facility Services cannot exceed the Maximums as indicated by the Plan.
2. No benefits are payable after the Covered Person or Eligible Dependent has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care; .when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person or Eligible Dependent with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person or Eligible Dependent; for the treatment of Substance Abuse or Mental Illness.

BB. SPINAL MANIPULATIONS

Benefits will be provided for spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

CC. SUBSTANCE ABUSE SERVICES

Benefits are provided for individual and group counseling and psychotherapy, psychological testing, and Family Counseling for the treatment of Substance Abuse when rendered to a Covered Person or Eligible Dependent by a Facility Provider or Professional Provider and include the following:

1. Inpatient Hospital or Substance Abuse Treatment Facility Services for detoxification;
2. Substance Abuse Treatment Facility Services for non-Hospital Inpatient residential treatment and rehabilitation Services; and
3. Outpatient Hospital or Substance Abuse Treatment Facility or Outpatient Substance Abuse Treatment Facility Services for rehabilitation therapy.

DD. SURGICAL SERVICES

1. **Anesthesia**
   Administration of Anesthesia for covered Surgery when ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at Surgery. Benefits are also provided for the administration of Anesthesia for covered oral surgical procedures in an Outpatient setting when ordered and administered by the attending Preferred Professional Provider.
2. **Assistant at Surgery**
   Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery; Benefits will be provided for an assistant at Surgery only if an intern, resident, or house staff member is not available.
3. **Second Surgical Opinion**
   a) A consulting opinion and directly related Diagnostic Services to confirm the need for recommended elective Surgery.
   b) Specifications
      i. The second opinion consultant must not be the Physician who first recommended elective Surgery.
      ii. Elective Surgery is covered Surgery that may be deferred and is not an emergency.
      iii. Use of a second surgical opinion is at the Covered Person's or Eligible Dependent's option.
      iv. If the first opinion for elective Surgery and the second opinion conflict, then a third opinion and directly related Diagnostic Services are covered services.
      v. If the consulting opinion is against elective Surgery and the Covered Person or Eligible Dependent decides to have the elective Surgery, the Surgery is a Covered Service. In such instances, the Covered Person or Eligible Dependent will be eligible for a maximum of two (2) such consultations involving the elective surgical procedure in question but limited to one (1) consultation per consultant.
4. **Special Surgery**
   a. Sterilization if deemed medically necessary.
   b. Oral Surgery - Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and Appropriate:
      i) extraction of impacted third molars when partially or totally covered by bone;
      ii) extraction of teeth in preparation for radiation therapy;

iii) mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures;
iv) mandibular frenectomy;
v) Facility Provider and Anesthesia Services rendered in conjunction with non-covered dental procedures when determined by the Plan to be Medically Necessary and Appropriate due to the age and/or medical condition of the Covered Person or Eligible Dependent;
vi) accidental injury to the jaw or structures contiguous to the jaw;
vii) the correction of a non-dental physiological condition which has resulted in a severe functional impairment;
viii) treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth; and
ix) Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

5. **Mastectomy and Breast Cancer Reconstruction** - Benefits are provided for a mastectomy performed on an Inpatient or Outpatient basis for the following:
   i) Surgery to reestablish symmetry or alleviate functional impairment including, but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;
   ii) Initial and subsequent prosthetic devices to replace the removed breast or portions thereof; and
   iii) Physical complications of all stages of mastectomy, including lymphedemas.

   Benefits are also provided for one (1) home visit, as determined by the Covered Person's or Eligible Dependent's Physician, when received within forty-eight (48) hours after discharge, if such discharge occurred within forty-eight (48) hours after an admission for a mastectomy.
6. **Surgery**

   Surgery performed by a licensed Health Care Provider. Separate payment will not be made for pre- and post-operative Services.

   If more than one (1) surgical procedure is performed by the same licensed Health Care Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, and no allowance shall be made for additional procedures except where the Plan deems that an additional allowance is warranted.

EE. THERAPY AND REHABILITATION SERVICES

Benefits will be provided for the following Covered Services only when such Services are ordered by a Physician:

1. Cardiac Rehabilitation;
2. Chemotherapy;
3. Dialysis Treatment;
4. Infusion Therapy - Benefits will be provided when performed by a Facility Provider and for self - administration if the components are furnished and billed by a Facility Provider.
5. Occupational Therapy;
6. Physical Medicine;
7. Radiation Therapy;
8. Respiratory Therapy;
9. Speech Therapy.

FF. THERAPEUTIC SERVICES

Therapeutic Injections required in the diagnosis, prevention and treatment of an injury or illness.

GG. TRANSPLANT SERVICES

Subject to the provisions of the Plan, benefits will be provided for covered services furnished by a Hospital which are directly and specifically related to the transplantation of organs, bones, tissues or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are Covered Persons or Eligible Dependents, each is entitled to the benefits under the Plan;
2. When only the recipient is covered, both the donor and the recipient are entitled to the benefits subject to the following additional limitations:
   a. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or any government program; and
   b. Benefits provided to the donor will be charged against the recipient's coverage to the extent that benefits remain and are available after benefits for the recipient's own expenses have been paid.
3. When only the donor is a Covered Person or Eligible Dependent, the donor is entitled to the benefits under the Plan, subject to the following additional limitations:
   a. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Contract, and
   b. No benefits will be provided to the non-Covered Person or Eligible Dependent transplant recipient;
4. If any organ, tissue or blood stem cell is sold rather than donated to the Covered Person or Eligible Dependent recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Covered Person or Eligible Dependent Recipient's Plan limits.

II. WIGS

The Plan covers the cost of wigs, if needed due to a specific diagnosis of chemotherapy induced alopecia.

JJ. WILM'S TUMOR

The Plan covers treatment of Wilm's Tumor the same way it covers charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. Coverage is available for this treatment even if it is deemed Experimental, Investigational or Unproven.

SECTION 5
PRESCRIPTION BENEFITS

Services and Supplies are provided to Covered Persons and eligible Dependents using the Magellan Rx Management Pharmacy Network.
Claims for prescription benefits services and supplies are determined by the Claims Administrator, or a delegate that is a pharmacy benefit manager. To use this benefit, simply present your Medical ID Card at any participating pharmacy. If you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please call 1-800-424-0472.

Schedule of Benefits and Prescription Co-payments/Co-insurance
Participants and Eligible Dependents must pay for a part of their prescription drug benefits in the form of a Co-Payment. For each prescription at a participating pharmacy or by mail order, you must pay the Co-Payment listed below. The Co-Payment is different for generic or brand name prescription drugs.
The Plan allows for the dispensing of up to a 30-day supply as prescribed by the Physician. Members may be able to obtain up to a 90-day supply of generic prescriptions at any pharmacy.
The mail order program was designed to allow Participants and Eligible Dependents to receive large quantities of maintenance medication (e.g., heart medication, blood pressure medication, diabetic medication, etc.). Participants and Eligible Dependents may obtain up to a 90-day supply of their prescription. The maximum benefit for covered prescription drug expenses Incurred by a Participant's entire family during each Plan Year may be obtained from your Claims Administrator. You may also call the Claims Administrator for advice on how to preserve and maximize your annual drug benefit.

REBATES AND OTHER DISCOUNTS
The Plan may, at times, receive rebates for certain drugs on the PDL. The Plan does not pass these rebates and other discounts on to you.

COVERED ITEMS

1. Aids
2. Alcohol Deterrents
3. Anabolic steroids
4. Antineoplastic/Chemo
5. Bee sting kits
6. Complementary Alternative Medicines
7. Compounded drugs
8. Contraceptives (Injectables, Oral, Patch, Diaphragms/Cervical, Progestin Implants)
9. Diabetic (Blood Sugar Diagnostics, Insulin, Insulin Syringes, Lancets, Urine Test Strips)
10. CSF/Hematopoietic Agents
11. Fluoride Preps – Oral & Topical
12. Folic Acid
13. Imitrex Injectable w/Std Qty Limit
14. Immunosuppressives
15. Injectables
16. Interferon Alpha Beta
17. Sexual Dysfunction – Oral and Non-Oral
18. Smoking Deterrent
19. Vitamins – Prenatal and Non-Prenatal
20. Yocon

EXCLUSIONS

In addition to the Exclusions and Limitations applicable to all benefits under the Plan (See Section 9), no Prescription Drug benefits are available under this Contract for:

1. Drug or medication which is not a covered maintenance prescription drug;
2. Any charges by any Pharmacy Provider or Pharmacist except as provided herein;
3. Any charge where the Allowable Charge is less than the Participant's or Eligible Dependent's Co-payment; and
4. Any charge above the Allowable Charge, advertised, or posted price, whichever is less than the Allowable Charge.
5. Drugs or medications available over-the-counter for which state or federal laws do not require a prescription.
6. Any drugs that are labeled as experimental or investigational.
7. United States Food and Drug Administration (FDA) approved prescriptions drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia, such as The United States Pharmacopoeia (USP) Drug Information, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, the Physician Drug Reference (PDR)) or in current medical literature. Medical literature means scientific studies published in peer-reviewed national professional medical journals.
8. Drugs newly approved by the FDA, prior to their review by the Plan's Pharmacy and Therapeutics Committee.
9. Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications.
10. Prescriptions covered without charge under federal, state or local programs, including Workers' Compensation
11. Any charge for the administration of a drug or insulin
12. Unauthorized refills
13. Medication for a Participant or Eligible Dependent confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity
14. Abortifacients
15. Alcohol Swabs
16. Anti-Obesity
17. Biologicals
18. Blood/Blood Products
19. Blood Pressure Supplies
20. Cosmetic Preps
21. Fertility Drugs
22. Hair Growth Stimulants
23. Immune Serums
24. Immunization/Vaccines
25. Metabolic Infant Formula
26. Miscellaneous Medical Supplies
27. Nutritional Diet Supplies
28. Ostomy Supplies
29. OTC
30. Respiratory Devices
31. Tuberculin Syringes
32. X-ray Diagnostics

SECTION 6
COORDINATION OF BENEFITS

Members of a family may be covered under more than one health program or insurance contract. This Coordination of Benefits provision is included in this Summary Plan Description to ensure that the Plan does not make duplicate payments, which can increase the cost of your health coverage.
This Coordination of Benefits applies to similar medical benefits payable under other health programs or insurance contracts, including:

a) Any group insurance coverage,
b) An Employer-sponsored or other pre-payment coverage,
c) Any coverage under labor-management trusteed Plans or Employee benefits Organization Plans, including this Plan,
d) Any coverage under government programs,
e) Any coverage required or provided by statute (except Medicaid),
f) Any mandatory "no-fault" coverage, and
g) Student coverage obtained or offered by an educational institution.

One of the two or more Plans is considered the "Primary Plan" and the others are the "Secondary Plans". The Primary Plan pays benefits first, without consideration of the other Plans. The Secondary Plans then make up the difference up to 100% of the Allowable Charges for each procedure. This Plan will never pay more than it would have paid without this provision. You must provide the Claims Administrator with any information necessary for administering this provision.

Excess Insurance
If at the time of Injury, sickness, disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.
The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation
When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Order of Benefit Determination
To determine which coverage is primary and which is secondary, the following rules apply:

i. The plan without a coordination of benefits provision similar to this one will be the primary plan.

ii. The plan in which the patient is the Covered Person (rather than a dependent) will be the primary plan. If your dependent child is covered under both your spouses' and your health plans, the primary coverage will be determined by the following factors:

iii. The plan of the parent whose birthday falls first during the year (regardless of year of birth) will pay first.

iv. If you and your spouse share the same birthday, the plan covering the parent longer will be primary.

v. If the other plan does not have a birthday provision and uses gender to determine primary responsibility, the father's plan will be primary.

vi. If you and your spouse are divorced or separated, and there is no court decree giving financial responsibility for your child's health care expenses to one parent, your dependent child will receive primary coverage under the custodial parent's health coverage program. The plan of the parent that was given financial responsibility for the child's health care by decree of the court is the Primary Plan.

vii. If you and/or your spouse remarries, the following order is used to determine primary responsibility for your dependent child's health coverage program:
   a) The parent with legal custody
   b) The spouse of the parent with legal custody
   c) The parent without legal custody
   d) The spouse of the parent without legal custody

viii. A patient's health coverage as an actively-employed Covered Person or as a dependent of an actively employed Covered Person this Plan is primary over other health care programs that they may have as either, a laid-off employee, a retired employee, or a dependent of a laid-off employee or a retired employee. If the other health care coverage is primary, then this rule will not apply.

If none of the previous rules apply, the plan that has covered the patient the longest will be the primary Plan.

If both a husband and wife are Covered Persons of this Plan, the benefit is calculated first as if this Plan was the Primary Plan and then as if this Plan was secondary. This will allow the same coverage as if the husband and wife were covered as Employees in two different plans.

If this Plan is the secondary plan and the primary plan is a health maintenance organization or preferred provider organization, then this Plan assumes that the primary plan pays the full value of the services and this Plan is the secondary plan only for any Deductible or Co- Payment under the primary plan. If you have coverage through your work under an HMO and this Plan is the secondary plan for you as a Dependent, you must follow the rules of the HMO in order to have remaining balances considered for payment by the Plan as the secondary plan. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to this Plan for payment, it will be denied. For purposes of coordinating benefits, an HMO is treated the same as any other plan. If you fail to follow the rules of any primary plan, this Plan will not pay benefits as either primary or secondary.

The Plan also has the right to collect any excess payment directly from the parties involved, from the other plan, or by an offset against any future benefit payment from the Plan on the Covered Person's or Dependent's behalf, if he or she failed to notify the Claims Administrator of the availability of other health coverage. This right of offset does not keep the Plan from recovering erroneous payments in any other manner.

To ensure that the Plan coordinates benefits with any other health plan coverage you have, you must keep the Plan informed of any and all coverage for you and your Dependents.

If the Plan has made payment of any amount that is in excess of that permitted by these Coordination of Benefits rules, the Claims Administrator has the right to recover such amount from any party who has

received such overpayment by requesting a refund from such party, crediting other claims against the amount owed to the Plan, or taking legal action.

COORDINATION WITH MEDICARE:

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits may also be entitled to Medicare coverage after a waiting period.

Medicare includes hospital insurance benefits (Part A) as well as supplementary medical insurance (Part B). In general, if you or a Dependent is enrolled in the Plan and in Medicare, the Plan will provide all benefits due under the Covered Person's Plan. Medicare may then pay any remaining charges, if such charges are covered under Medicare. In technical terms, the Plan is "primary" (pays first) for your covered medical and hospital expenses, while Medicare is "secondary" (pays second).

Disabled Employees or Disabled Dependents Under 65: This Plan is primary for enrolled, active Employees or their Dependents who are under age 65 and for Employees or their Dependents who have a Social Security Disability Award and are entitled to Medicare benefits due to total disability (other than End Stage Renal Disease).

End Stage Renal Disease: If, while you are in active employment and you or any of your Dependents become entitled to Medicare because of End Stage Renal Disease (ESRD), this Plan pays primary and Medicare pays secondary for 30 months starting with the earlier of (1) the month in which Medicare ESRD coverage begins; or (2) the first month in which the individual receives a kidney transplant. This provision does not apply if Federal law provides to the contrary. In this case, the benefits of the Plan will be determined in accordance with such law.

Medicaid: If you are covered by both this Plan and Medicaid, this Plan is primary and Medicaid pays secondary.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services): If you are covered by both this Plan and CHAMPUS, this Plan pays as primary and CHAMPUS pays secondary.

Other Coverage Provided by State or Federal Law: If you are covered by both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law is primary and this Plan is secondary.

SECTION 7
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage

and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes,

which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s) or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION 8
WORKER'S COMPENSATION CASES

No benefits will be paid by this Plan for an accident or Illness in any way connected with Employment. If you have a Work-Related accident or Illness, notify your Employer immediately and file a Worker's Compensation claim with your Employer.

Certain Illnesses like hernias, varicose veins, allergy to chemicals or materials may occur due to the nature of the work in the industry. Since Worker's Compensation offers certain protections if you have such an Illness, discuss your job activities with the doctor to determine if it could be Work-Related.

Failure to file a Worker's Compensation claim could mean the loss of benefits which might otherwise protect you against medical costs or loss of earnings resulting from a Work-Related accident or Illness.

SECTION 9
EXCLUSIONS

DENIAL OR LOSS OF BENEFITS

In addition to the exclusions and limitations set forth in the various benefit sections of this SPD, the following circumstances may cause loss of benefits and/or charges and expenses which are not payable from the Plan.
Benefits are denied when it is determined that, at the time the claim was Incurred, you or your Dependent, as the case may be:

i. Was not eligible for benefits claimed.
ii. Failed to submit required evidence to substantiate the claim.
iii. Failed to apply or make timely application for benefits.
iv. Made intentional material misstatements in connection with eligibility or any payments made in reliance on such misstatement.
v. Omitted facts or material statements as to other insurance available to you and your Dependents

Each benefit section of this SPD may contain limitations and exclusions that apply to that particular benefit. The following exclusions and limitations apply to all benefits under the Plan except as otherwise specifically indicated in this Plan. Benefits under the Plan do not include coverage for:

1. Any service which is not deemed medically necessary as determined by the Plan or does not meet the plan's guideline for clinical eligibility for coverage;

2. Services that are not Clinical eligibility for coverage: Except for preventive services required to be covered under the Affordable Care Act, all services unrelated to an Illness or Injury are excluded; as is all or any part of a hospital stay related to an unnecessary service including any services provided during that period (except where otherwise provided);

3. Services which are not prescribed by or performed by or upon the direction of a licensed, Health Care Provider;

4. Services for any Experimental procedures, services, or drugs. For example, hospital stays for any procedure that is no longer generally regarded as effective or it is experimental in the sense that its effectiveness is not generally recognized;

5. Services rendered prior to the Covered Person's or Eligible Dependent's Effective Date;

6. Services Incurred after the date of termination of the Covered Person's or Eligible Dependent's coverage;

7. Services rendered after the visit limit per covered service is reached;

8. Services for loss sustained or expenses Incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses Incurred as a result of an act of war whether declared or undeclared;

9. Services rendered in connection with an Illness or Injury that is Incurred or is a result of a declared or undeclared war or military services;

10. Services which no charge is made or which a Covered person or Eligible Dependent would have no legal obligation to pay;

11. Services rendered when a Covered Person intentionally omits or misrepresents health information in their enrollment application. If such intentional omission or misrepresentation is discovered after the Covered Person enrolls, such Covered Person will be classified as a non-qualifying Covered Person and the Plan will not pay any of that Covered Person's claims;

12. Hospital admissions due to illegal Surgery or for dentistry (except as the result of an accident);

13. In connection with an Injury or Illness arising out of a procedure, surgery or treatment performed by a Doctor/Facility/Provider that causes harm to a Covered Person or Eligible Dependent;

14. Charges arising from care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator;

15. Services which are not consistent with the diagnosis and treatment of a condition;
16. For services, supplies and treatment unless performed or prescribed as necessary by a legally licensed Physician;

17. Confinement primarily for custodial or for rest cures, respite or, for long-term care;

18. Any amounts the Covered Person or Eligible Dependent is required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplemental coverage;

19. Hospitalization furnished under federal, state and other laws for which the government program is primary;

20. Services in connection with an injury or Illness arising out of or in the course of Employment for which benefits are payable under Worker's Compensation Laws. This exclusion applies whether or not the Covered Person or Eligible Dependent files a claim for said benefits or compensation;

21. Any benefits provided to members of the armed forces while on active duty or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the Covered Person or Eligible Dependent has a legal obligation to pay;

22. Treatments or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;

23. Services rendered when no Fault is primary. If a claim is denied because of illegal substance use or DUI, then Plan will also not cover any deductible or dollar amount over the insured's limit. The Plan will not cover charges denied under no fault insurance because the claimant did not have no fault coverage in violation of New York or other state insurance laws;

24. Prescription Drugs which were paid or are payable under a freestanding prescription drug program;

25. Charges arising from care, supplies, treatment, and/or services that are services, supplies, care or treatment to a Covered Person for Injury or sickness Incurred while the Covered Person was

voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

26. Expenses for nicotine gum or patches, or other products, services or programs intended to assist an individual to stop smoking, except to the extent required by the Affordable Care Act;

27. Charges arising from care, supplies, treatment, and/or services that are involving a Covered Person who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

28. Ambulance services, except as provided herein;

29. Plastic surgery for cosmetic purposes. Exceptions to this exclusion include:
    - Surgery to correct a condition resulting from an accident;
    - Surgery to correct a congenial birth defect;
    - Surgery to correct a functional impairment which results from a covered disease or injury;

30. Services for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a medical or other Professional Provider;

31. Inpatient admissions which are primarily for diagnostic studies or for Physical Medicine services;

32. Outpatient Therapy and Rehabilitation Services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur; unless Medically Necessary and Appropriate;

33. Services of private or special nurses or services generally provided on an out-patient basis;

34. Dental care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily injury to sound and natural teeth and for orthodontic treatment for congenital cleft palates;

35. Oral Surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, except as provided herein;

36. Treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

37. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;

38. Hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, except as provided here in;

39. Routine hearing exam unless mandated by law;

40. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury);

41. Voluntary Sterilization – not of Medical Necessity and Appropriateness, unless it is for female sterilization procedures that are otherwise covered under the Preventive Care Services benefit;

42. The correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Kratomileusis (LASIK) and all related services;

43. Nutritional counseling, except as provided herein;

44. Any weight loss or control, including all diagnostic testing related to weight reduction programs, unless it provides for the treatment of Morbid Obesity;

45. Any surgical procedure not Medically Necessary and Appropriate;

46. Allergy testing, except as provided herein or as mandated by law;

47. Membership fees, dues or any other charges in connection with recreational facilities, fitness centers, diet, stress management centers or nutritional centers, recreational and leisure travel even if prescribed or recommended by a Physician;

48. Immunizations required for foreign travel or employment;

49. Expenses for the treatment of infertility and its complications, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, adoption, and reversal of sterilization procedures;

50. Services ordered by a court or other tribunal as part of the Covered Person's and Eligible Dependent's sentence;

51. Charges arising from care, supplies, treatment, and/or services that are for any Injury or sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

52. Genetic testing or counseling, unless used to treat the sickness or injury of a covered person or used in the treatment of a high-risk pregnancy, or unless otherwise covered under the Preventive Care Services;

53. Transportation charges to and from health care providers except as specified herein;

54. Care for surrogate mothers, unless the surrogate is a Covered Person, in which case the Preventive Care Services and/or pregnancy expenses will be covered in accordance with the Plan provisions;

55. Coverage for hair loss;

56. Coverage for marriage or family counseling;

57. Educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aids, auditory aids, speech aids, etc., even if they are required because of an Injury or Illness;

58. Physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party;

59. Prayer, religious healing, spiritual healing, naturopathic, naprapathic, homeopathic services or supplies, hypnosis, hypnotherapy, biofeedback;

60. Acupuncture;

61. Private Duty Nursing

62. Work-Related claims

63. Massage therapy, Rolfing and related services; or

64. Any other medical or dental Service or treatment except as provided in the Plan or as mandated by law.

65. Services or supplies furnished by one of these members of the Covered Person's family, unless otherwise stated herein. This includes a Spouse, or Domestic Partner, child, parent, in-law, brother or sister;

66. Services for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

67. Services for which the Covered Person would not have been charged if he/she did not have health care coverage;

68. Services provided by a social worker, except as otherwise stated in this SPD;

69. Administration of oxygen, except as otherwise stated herein.

70. Anesthesia and consultation services when they are given in connection with Non-Covered Expenses or billed separately by a Practitioner for Surgery performed on an Outpatient basis;

71. Charges arising from care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document;

72. Blood or blood plasma or other blood derivatives or components that are replaced by a Covered Person;

73. Consumable medical supplies;

74. Home Health Care Visits: connected with administration of dialysis;

75. Sunglasses, even if by prescription;

76. Light box therapy, and the appliance that radiates the light;

77. Housekeeping services, except as an incidental part of Covered Services and Supplies furnished by a Home Health Agency;

78. Maintenance therapy for:
    - Physical Therapy;
    - Manipulative Therapy;
    - Occupational Therapy; and
    - Speech Therapy;

79. Milieu Therapy:
    Inpatient services and supplies which are primarily for milieu therapy even though covered treatment may also be provided.
    This means that Claims Administrator has determined that:
    - the purpose of all or part of an Inpatient stay is chiefly to change or control a patient's environment; and
    - an Inpatient setting is not Medically Necessary and Appropriate for the treatment furnished, if any;

80. Food products (including enterally administered food products, except when used as the sole source of nutrition). But, this exclusion does not apply to the foods, food products and specialized non-standard infant formulas that are eligible for coverage as stated herein;

81. Pastoral counseling;

82. Psychoanalysis to complete the requirements of an educational degree or residency program;

83. Psychological testing for educational purposes;

84. Removal of abnormal skin outgrowths and other growths. This includes, but is not limited to, paring or chemical treatments to remove: corns; callouses; warts; hornified nails; and all other growths, unless it involves cutting through all layers of the skin. This does not apply to services needed for the treatment of diabetes;

85. Special medical reports not directly related to treatment of the Covered Person (e.g., employment physicals; reports prepared due to litigation.);
86. Telephone consultations;
87. Vitamins and Dietary Supplements;
88. Expenses in connection with unless specifically provided for herein), donor semen, adoption, and reversal of sterilization procedures;
89. Charges arising from care, supplies, treatment, and/or services that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation;
90. Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Covered Person's having failed to honor an appointment;
91. Charges arising from care, supplies, treatment, and/or services that are expenses actually Incurred by other persons;
92. Charges arising from care, supplies, treatment, and/or services that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA);
93. Charges arising from care, supplies, treatment, and/or services that are not specified as covered under any provision of this Plan;
94. Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law;
95. Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable Provider error;
96. Charges arising from care, supplies, treatment, and/or services that are for an Illness, Injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions; and
97. Charges arising from care, supplies, treatment, and/or services that are not reasonable in nature or in charge (see definition of Maximum Allowable Charge), or are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Any Covered Person who improperly collects benefits from the Plan, based on misstatement or misrepresentation, will be legally liable for the reimbursement to the Plan of any improper payments. In addition, the Covered Person will be subject to suspension of all benefits.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

SECTION 10
HOW TO CLAIM YOUR BENEFITS

You will receive a Plan identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your network, and your cost containment program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you, however you may file a claim yourself by submitting the required information to the Plan.

Procedures for All Claims
The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan.

Health Claims
All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.
Each Covered Person or Eligible Dependent claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Covered Person has not Incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person or Eligible Dependent fails to furnish such proof as is requested, no benefits will be payable under the Plan.
Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.
Pre-service Claims A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
A "Pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's or Eligible Dependent's medical condition, would subject the Covered Person or Eligible Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
It is important to remember that, if a Covered Person or Eligible Dependent needs medical care for a condition which could seriously jeopardize his life; there is no need to contact the Plan for prior approval. The Covered Person or Eligible Dependent should obtain such care without delay and then later file the claim as a Post-Service claim.
Further, if the Plan does not require the Covered Person or Eligible Dependent to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person or Eligible Dependent simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.
Concurrent Claims A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan Administrator determines that the course of treatment should be reduced or terminated; or

- The Covered Person or Eligible Dependent requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Since the Plan does not require that the Covered Person or Eligible Dependent obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Covered Person should simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment and file the claim as a post-service claim.

Post-Service Claims

A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

i. The date of service;
ii. The name, address, telephone number and tax identification number of the provider of the services or supplies;
iii. The place where the services were rendered;
iv. The diagnosis and procedure codes;
v. The amount of charges (including network re-pricing information);
vi. The name of the Plan;
vii. The name of the covered employee; and
viii. The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

When Health Claims Must Be Filed

All claims must be filed at the Claims Administrator on the appropriate form. A Covered Person may obtain the necessary forms for filing a claim by telephone at (888) 721-2128) or writing to the Claims Administrator at 14 Wall Street, Suite 5B, New York, NY 10005. All necessary information must accompany your claim in order for the Plan to process the claim effectively.

There is a one-year (365 days) time limit from the date services were received for filing medical claims. Any claim received after this time limit will be denied.

IMPORTANT NOTE: You and your Dependents should be aware that you or your medical provider's failure to file the claim for benefits within the one-year (365 days) deadline will mean that your claim is late and will not be paid by the Plan. Consequently, the medical provider may seek to collect any money it is owed directly from you. It is therefore very important that you make sure that you or your provider submit your medical claims within the one-year (365 days) time frame.

Additionally, if the Plan denies or partially denies any claim for benefits that you do make, you or your provider must appeal the denial within the one hundred and eighty (180) days as explained in Section 11 if you wish to contest the Plan's decision. A failure to request this review binds you and your provider to accept the amount, if any, that the Plan has already paid regarding the claim. The Plan will not pay any claims after the time to appeal a denial has elapsed and the medical provider may seek to collect any money it is owed directly from you.

You must file a completed claim form each time you submit a bill directly to the Plan. If you wish the Claims Administrator to pay the provider of services directly, you must provide us with your original signature (not a photocopy) authorizing us to do so. Please be sure to indicate on the claim form if there is an Injury involved, a lawsuit or third-party recovery, or any change in your marital status, you or your spouse's employment status or eligibility for other medical coverage.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the Covered Person or Eligible Dependent of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of the Plan's Claim Decisions

The Plan Administrator shall notify the Covered Person or Eligible Dependent, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

i. Pre-service Non-Urgent Care Claims:

- If the Covered Person or Eligible Dependent has provided all of the information needed to process the claim, the Plan shall notify the Covered Person of the Plan's decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the Covered Person or Eligible Dependent has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim (24 hours in the case of a failure to file a claim involving urgent care). The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

ii. Concurrent Claims:

- Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the Plan shall make the notification before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Request by Covered Person or Eligible Dependent Involving Non-Urgent Care. If the Plan Administrator receives a request from the Covered Person or Eligible Dependent to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

iii. Post-service Claims.

- If the Covered Person or Eligible Dependent has provided all of the information needed to process the claim, the Plan shall notify the Covered Person within a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the Covered Person or Eligible Dependent has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person or Eligible Dependent will be notified of a determination of benefits

prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person or Eligible Dependent will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

iv. Extensions – Pre-Service Non-Urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

v. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator may provide notifications of adverse benefit determinations either by letter or electronically. Every notice of an adverse benefit determination shall include:

- Information sufficient to identify the claim involved, including the date of the service, the name of the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- A reference to the specific portion(s) of the summary plan description upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's or Eligible Dependent's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

SECTION 11
CLAIM APPEAL PROCEDURE

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been wrongly denied, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- Covered Persons 180 days following receipt of a notification of an initial adverse benefit determination to appeal the determination;
- Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
- That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's or Eligible Dependent's claim for benefits in possession of the Plan Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's or Eligible Dependent's medical circumstances.

Requirements for Appeal

The Covered Person must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a personal representative.

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

Mail:
Leading Edge Administrators
14 Wall Street, Suite 5B
New York, NY 10005
Fax: (646) 559-1810

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the Covered Person;
- The name of the patient;
- The Covered Person's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the claim; and
- Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information the Plan Administrator will be able to decide the appeal.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

- **Pre-service Non-Urgent Care Claims**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- **Concurrent Claims**: The response will be made in the appropriate time period based upon the type of claim –pre-service non-urgent or post-service.
- **Urgent Care Claims**: Within a reasonable period of time, but not later than 72 hours after receipt of the appeal.
- **Post-service Claims**: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

If, upon appeal, The Plan Administrator denies a Covered Person's appeal, either in whole or in part, the Plan Administrator shall provide the Covered Person with notification, in writing or electronically, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the summary plan description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's or Eligible Dependent's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline,

protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's or Eligible Dependent's medical circumstances, will be provided free of charge upon request;
- A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review;
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Covered Persons with the internal claims and appeals and external review processes;
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency"; and
- Access to, and copies of, documents, records, and other information described in this section, as appropriate.

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review

When a Covered Person has exhausted the internal appeals process outlined above, the Covered Person has a right to have that decision reviewed by independent health care professionals who have no association with the Plan, the Plan Sponsor, or the Plan. If the adverse benefit determination involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request for external review within 4 months after receipt of a denial of benefits to:

American Health Holdings, Inc.
7400 West Campus Road, F-510
New Albany, OH 43054
(888) 974-5702

For standard external review, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. Please contact your Plan Administrator with any questions on your rights to external review.

Appointment of Authorized Representative

A Covered Person or Eligible Dependent is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person or Eligible Dependent to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person or Eligible Dependent must complete a form which can be obtained from the Employer or Claims Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's or Eligible Dependent's medical condition to act as the Covered Person's or Eligible Dependent's authorized representative without completion of this form. In the event a Covered Person or Eligible Dependent designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person or Eligible Dependent, unless the Covered Person or Eligible Dependent directs the Claims Administrator, in writing, to the contrary.

Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person or Eligible Dependent whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the Covered Person whose illness or injury, or whose Eligible Dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Claims Administrator may, in its sole discretion, authorize any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such Covered Person.

Assignments

Assignment by a Covered Person to the Provider of the Covered Person's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Covered Person – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Covered Person's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Covered Person shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan or following his or her termination as a Covered Person, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. This prohibition applies to Providers as well.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under

the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.
Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-US provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. provider;
- Non-emergency care outside of the U.S. is not covered unless a life-threatening condition applies. In that instance care would be covered subject to approval from Claims Administrator. Claims will be capped at $5,000 per member;
- The Covered Person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Claims Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or Eligible Dependent on whose behalf such payment was made.
A Covered Person, Eligible Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Claims Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.
The person or entity receiving an erroneous payment may not apply such payment to another expense. The Claims Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person, Eligible Dependent or other entity does not comply with the provisions of this section, the Claims Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person, Eligible Dependent, or other entity and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Claims Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Claims Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Eligible Dependent, provider or other person or entity to enforce the provisions of this section, then that Covered Person, Eligible Dependent, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Legal Action for Benefits

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied.

Note that: All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three hundred and sixty-five (365) days after the Plan's claim review procedures have been exhausted.

SECTION 12 -
Notifications

Section 1557 Compliance

Plan Sponsor intends to comply with any applicable Federal and state laws regarding discrimination on the basis of race, color, national origin, age, disability or sex in respect of this Plan, and shall administer the Plan, including that it shall interpret, amend and construe the Plan benefits and exclusions to the extent such laws are deemed applicable, as determined by the Plan Administrator in its sole discretion.

Providence Health Group, LLC. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Group, LLC. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Group, LLC.:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages

If a Covered Person needs these services, he or she should contact Providence Health Group, LLC. HR Department at Phone: 1-866-268-7870

If a Covered Person believes that Providence Health Group, LLC. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with: Providence Health Group, LLC. HR Department Phone: 1-866-268-7870. The Covered Person can file a grievance in person or by mail, fax, or email. If a Covered Person needs help filing a grievance, Providence Health Group, LLC. HR Department personnel is available to help him or her.

Covered Persons can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-1-866-268-7870（TTY：1-xxx-xxx-xxxx）。

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-1-866-268-7870 (TTY: 1-xxx-xxx-xxxx)번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-268-7870 (رقم هاتف الصم والبكم: 1-xxx-xxx-xxxx).

Tagalog – Filipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-268-7870 (телетайп: 1-xxx-xxx-xxxx).

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx) पर कॉल करें।

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-268-7870 (ATS : 1-xxx-xxx-xxxx).

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-866-268-7870 (TTY: 1-xxx-xxx-xxxx).

Model Newborn Act's Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than the 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 or 96 hours as applicable.

Women's Health and Cancer Rights Act Notice

If you had or are going to have a mastectomy, you may be entitled to certain benefits under Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce asymmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits

The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") and ERISA prohibit group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. Accordingly, the Plan does not discriminate on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

i. An individual's genetic tests;
ii. The genetic tests of family members of an individual; and
iii. An individual's family members' manifested diseases or disorders.

A genetic test is an analysis of human chromosomes, DNA, RNA or proteins that detects genotypes, mutations, or chromosomal changes.

For example, a genetic test includes a test to determine whether someone has the BRCA1 or BRAC2 variant indicating a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer and a test for a genetic variant for Huntington's disease.

The Plan will not require that a Covered Person undergo a genetic test.

GINA also prohibits the Plan from requesting or requiring disclosure of genetic information of an individual or a family member of the individual, except as specifically allowed by GINA. To comply with this law, the Plan asks that you do not provide any genetic information when responding to any Plan request for medical information.

SECTION 13
CONTINUATION OF COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA, generally requires that health plans offer Plan Covered Persons and their Eligible Dependents the opportunity to temporarily continue their health care coverage at group rates when coverage under the Plan would otherwise end. This extended coverage is called "COBRA Coverage". COBRA Coverage under the Plan includes all benefits that the person was entitled to before the Qualifying Event.
If you, your spouse and/or your Dependent child(ren) are covered under the Plan, you and/or your spouse or children can continue coverage for a time if coverage ends for one of several reasons (called "Qualifying Events"), even if you or they are already covered by another group health Plan or Medicare.
Qualifying events are certain events that would cause you or your dependent to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and how long the Plan must offer them COBRA coverage.

Qualifying Events for Employees:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct;
- Reduction in the number of hours of employment resulting in a loss of eligibility for health benefits.

Qualifying Events for Spouses:

i. Voluntary or involuntary termination of the Employee's employment for any reason other than gross misconduct;
ii. Reduction in the hours worked by the Employee resulting in a loss of eligibility for health benefits;
iii. Employee becomes entitled to Medicare;
iv. Divorce or legal separation from the Employee;
v. Death of the Employee.

Qualifying Events for Dependent Children:

i. Loss of dependent child status under the plan rules;
ii. Voluntary or involuntary termination of the Employee's employment for any reason other than gross misconduct;
iii. Reduction in the hours worked by the Employee resulting in a loss of eligibility for health benefits;
iv. Employee becomes entitled to Medicare;
v. Death of the Employee.

If you and/or your Dependents do not elect COBRA Coverage, you and/or your Dependent's group health coverage will end if one of these Qualifying Events occurs.

Reporting Requirements

Your Employer must notify the Claims Administrator if the Employees' employment is terminated, his or her hours are reduced resulting in a loss of eligibility for health benefits, he or she becomes entitled to Medicare or he or she dies. This notification must be in writing and must be provided within thirty days of the Qualifying Event. Failure to provide such timely notification may subject the Employer to federal excise taxes.
The Covered Person or the affected Dependent must notify the Claims Administrator within 60 days of divorce, legal separation or loss of eligibility by a Dependent child. Both the Covered Person and the affected Dependent are jointly responsible for this notice. If you or your Dependent fails to give written

notice to the Claims Administrator within the required sixty days, the affected person will lose the right to COBRA Coverage.

Financial Responsibility for Failure to Give Notice

If you or your Dependent fails to give written notice within sixty (60) days of the date of the Qualifying Event, or an Employer within thirty days of the Qualifying Event, and as a result, the Plan pays a claim for an individual Person whose coverage terminated due to a Qualifying Event and who does not elect COBRA Coverage under this provision, then you, your Dependent or the Employer, as appropriate, must reimburse the Plan for any claims that should not have been paid. If you or your Dependent fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of you or your Dependent.

Notice and Election Form

COBRA Coverage requires timely election of the coverage. The Claims Administrator will, within fourteen (14) days of receiving notice of the Qualifying Event, send to the affected person a COBRA Notice and Election Form. This form will describe the cost of coverage and the conditions under which the COBRA Coverage will terminate. In order to obtain COBRA Coverage, the Election Form must be completed and returned to the Claims Administrator within sixty (60) days after receipt.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace

coverage until the next open enrollment period and could end up without any health coverage in the interim.
Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.
If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Details of Continuation Coverage
If you choose COBRA Coverage, the coverage provided is identical to the coverage provided under the Plan to similarly situated Covered Persons. If the coverage provided under the Plan is modified after you elect COBRA Coverage, your coverage also will be modified.
Children born to or placed with you for adoption during the COBRA period also may receive coverage for the duration of your COBRA Coverage period.
You do not have to show that you are in good health to elect COBRA Coverage. However, under COBRA, you will have to pay the cost for your Continuation Coverage. COBRA Coverage requires timely monthly payments. The payment due date is the first day of the month in which COBRA Coverage begins. For example, payments for the month of November must be paid on or before November 1st.
The monthly cost of COBRA Coverage is based on 102% of the full monthly cost of the coverage under the Plan. If any individual or family coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits (described below), the cost of COBRA Coverage is based on 150% of the full monthly cost of COBRA coverage during the 11-month extension of COBRA Coverage. The Claims Administrator will tell you the cost of COBRA Coverage at the time you receive your notice of entitlement to COBRA Coverage.
There is an initial grace period of 45 days to pay the first amounts due starting with the date COBRA Coverage was elected. The payment due for the initial period of COBRA Coverage must include payment for the period of time dating back to the date that coverage terminated. There is then a grace period of 30 days after the due date for each of the subsequent monthly amounts due. If payment of the amounts due is not received by the end of the applicable grace period, the COBRA Coverage will terminate.
Once a timely election of COBRA Coverage has been made, it is the responsibility of the affected person seeking COBRA Coverage to make timely payment of all required payments. The Claims Administrator will not send notice that a payment is due or that it is late, or that COBRA Coverage is about to be or has been terminated due to the untimely payment of a required payment.
Maximum Periods of COBRA Coverage for Each Qualifying Event:

Qualified Beneficiary	Qualifying Event	Period of Coverage
Employee Spouse Dependent child	Termination Reduction in hours	18 months (This 18-month period may be extended for all qualified beneficiaries if certain conditions are met in cases where a qualified beneficiary is determined to be disabled for purposes of COBRA.
Spouse Dependent child	Entitled to Medicare Divorce or legal separation Death of covered employee	36 months
Dependent child	Loss of dependent child status	36 months

If your Dependent's coverage is continued for 18 months as a result of a Qualifying Event listed above and, during the COBRA period, a second Qualifying Event occurs that entitles the Dependent to continue

coverage, your Dependent may elect to continue coverage up to a combined maximum of 36 months. For example, if you retire and you and your Dependents elect COBRA Coverage from May 1, 2016 and you then become entitled to Medicare on November 1, 2016, your Dependents can elect to continue coverage for the balance of 36 months, measured from May 1, 2016.

If your coverage is continued under the Plan after you stop working because of one of the Qualifying Events listed in this Section, your COBRA Coverage period will be measured from the date that your coverage ends.

Entitlement to Social Security Disability Income Benefits

Extended COBRA Benefits

29-Month Period (Disability Extension): If a qualified beneficiary of COBRA benefits is determined under Title II or XVI of the Social Security Act to have been disabled within the first 60 days of the commencement of COBRA coverage, then that qualified beneficiary and all of the qualified beneficiaries in his or her family may be able to extend COBRA continuation coverage for up to an additional 11 months. In addition, a qualified beneficiary who has been determined under Title II or Title XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage, and who has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage, is considered to be disabled within the first 60 days of COBRA continuation coverage.

The qualified beneficiary may lose all rights to the additional 11 months of coverage if notice of the determination is not provided to the Claims Administrator within 60 days of the date of the determination and before the expiration of the 18-month period. The qualified beneficiary who is disabled or any qualified beneficiaries in his or her family may notify the Claims Administrator of the determination.

18 to 36-Month Period (Special Rule): If an Employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a termination of employment or a reduction of employment hours, the period of coverage for the Employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the Employee became entitled to Medicare, or the 18 or 29 month period that begins on the date of the Employee's termination of employment or reduction of employment hours. However, the Employee's Medicare entitlement is not a qualifying event because it does not result in loss of coverage for the Employee's dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.

18 to 36-Month Period (Second Qualifying Event): Your spouse and dependent children who experience a second qualifying event may be entitled to a total of 36 months of COBRA coverage. The second qualifying event may include your death, the divorce or legal separation from the Employee, your entitlement to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under this Plan. The following conditions must be met in order for a second event to extend a period of coverage:

1. The initial qualifying event is the Employee's termination, or reduction of hours, of employment, which calls for an 18-month period of continuation coverage;
2. The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);
3. The second event would have caused a qualified beneficiary to lose coverage under the Plan in the absence of the initial qualifying event;
4. The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and
5. The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the Claims Administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

Termination of COBRA Coverage

If you and/or your Dependent elect COBRA Coverage, the Cobra Coverage will cease on the first of the following dates:

- The date the Plan terminates or the Plan no longer provides coverage to similarly situated Covered Persons or Dependents.
- The date a required payment is due and unpaid after the applicable grace period.
- The date you and/or your Dependent(s) first become covered under another group health Plan as long as it is after the Qualifying Event.
- The date you or your Dependent(s) first become eligible for Medicare, as long as it is after the Qualifying Event.
- The date the applicable period of COBRA Coverage ends; or
- The first month that begins more than thirty days after the date of the Social Security Administration's determination that you or your Dependent(s) are no longer disabled, in situations where coverage was being extended for eleven months, so long as the period of Continuation Coverage does not exceed twenty-nine months.
- Your Employer ceases to maintain health insurance coverage for its Employees with the Plan.

SECTION 14
IMPORTANT INFORMATION ABOUT THE PLAN

The Plan is sponsored by your employer, Providence Health Group, LLC. and administered by Leading Edge Administrators.

Your employer's address is:
110 Glancy St. Suite 114
Goodlettsville, TN 37072

The Plan Administrator's Address is:
Providence Health Group, LLC.
110 Glancy St. Suite 114
Goodlettsville, TN 37072

Plan Benefits: All of the types of benefits provided by the Plan are set forth in this Plan SPD. Except for those benefits that may become payable for Hospital, surgical, or other medical expenses, no rights or benefits may be assigned.

Name of Plan:
Providence Health Group, LLC. MEDICAL PLAN
Employer Identification Number (EIN): 46-2491019

Type of Plan:
An employee welfare benefits plan, including medical and prescription drug benefits.

ERISA Plan Number: 501

Plan Status under the Affordable Care Act: Non-Grandfathered

Type of Administration:
Third Party Administration
This Plan is self-insured. There is no insurance company to collect premiums or underwrite coverage. Instead, contributions from you and your Employer pay all benefits. Prior claims experience and forecasted expenses are used to determine the amount of money needed to pay future benefits. This Plan is governed by federal laws, not by state insurance laws.

Agent for Service of Legal Process:
14 Wall Street, Suite 5B
New York, NY 10005

CLAIMS ADMINISTRATOR
Leading Edge Administrators
14 Wall Street, Suite 5B
New York, NY 10005

Plan Year:
The Plan's fiscal records are kept on a twelve-month period beginning each January 1st and ending on the following December 31st.

Legal Entity; Service of Process:
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Applicable Law:
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority:
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

SECTION 15
ADMINISTRATION OF THE PLAN

The Plan is administered by the Plan Administrator, which has the discretionary authority to control and manage the operation of the Plan. The Administrator has the power, in its sole discretion, to administer the Plan in all of its details, including, but not limited to, the following powers:

1. Interpretation of the Plan, including determinations as to eligibility and entitlement for Plan benefits, such interpretation are final and conclusive on all individuals claiming rights under the Plan;
2. Adoption of procedures and regulations as in its opinion are necessary for the proper and efficient administration of the Plan and are consistent with the terms and purposes of the Plan;
3. Enforcement of the Plan according to its terms, rules and regulations;
4. The responsibility to administer and manage the Plan;
5. The responsibility to prepare, report, file and disclose any forms, documents and other information required by law or otherwise to be reported or filed with any governmental agency, or to be prepared and disclosed to all Covered Persons or other persons entitled to benefits under the Plan;
6. Maintenance of records necessary for administration of the Plan;
7. The discretionary authority to require any Covered Person to furnish any documentation that it may deem necessary to substantiate the eligibility of a Covered Person or Eligible Dependent for the purpose of the proper administration of the Plan and as a condition to receiving any benefit under the Plan, wherein refusal or failure to submit such documentation may result in the withdrawal of enrollment of such dependent; and
8. The responsibility to review claims or claim denials and to determine benefit eligibility under the Plan.

Notwithstanding the foregoing, the Plan Administrator may delegate to, Third-Party Administrators, organizations or persons (who also may be Employees) specific fiduciary responsibilities in administering the Plan. Any such delegation must be in writing and, to the extent applicable, in accordance with ERISA or other applicable law.

Determinations of the Plan Administrator as to any question involving the general administration and interpretation of the Plan are be final, conclusive and binding upon all persons claiming any interest in or under the Plan except as otherwise provided by law. Any discretionary actions to be taken under the Plan by the Plan Administrator shall not be subject to de novo review if challenged in court, by arbitration or in any other forum, and shall be upheld unless found to be an abuse of discretion.

SECTION 16
MISCELLANEOUS

State of Jurisdiction
Except to the extent superseded by the laws of the United States, the Plan and all rights and duties thereunder are governed, construed, and administered in accordance with the laws of the State of New York.

Severability
If any provision of the Plan is held invalid or unenforceable, its invalidity or enforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

Plan Not an Employment Contract
The Plan is not an employment contract. Nothing in the Plan shall be construed to limit in any way the right of an Employer to terminate an Employee's employment at any time for any reason whatsoever, with or without cause.

Mistake of Fact
Any mistake of fact or misstatement of fact shall be corrected, and proper adjustment made by reason thereof, to the extent practicable, provided that such mistake or misstatement is brought to the attention of the Administrator or its delegate within a reasonable time.

Titles and Headings
The captions preceding the provisions of the Plan are used solely as a matter of convenience and in no way define, modify or limit the scope or intent of any provision of the Plan.

No Liability for Practice of Medicine
The Plan is not engaged in the practice of medicine nor do any of them have any control over any diagnosis treatment care or lack thereof, or any health care services provided or delivered to any Covered Person by any health care provider. The Plan will not have any liability whatsoever for any loss or injury caused to any Covered Person by any health care provided by reason of negligence, by failure to provide care or treatment, or otherwise. All medical decisions are between the patient and the physician and do not involve the Plan.

SECTION 17
HIPAA PRIVACY PRACTICES

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 888-721-2128.

The following is a description of certain uses and disclosures that may be made by the Plan of your health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Notify Covered Persons of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule.
- Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule.
- Report to the Plan any PHI uses or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI to the Covered Person in accordance with the privacy standards.
- Make a Covered Person's PHI available for the Covered Person to amend to the extent required by the privacy rules.
- Make available the information required to provide an accounting of disclosures.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the privacy standards.
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required by the privacy rules.

The Claims Administrator is the contact person for all PHI information requests.

In the event any of the individuals do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Claims Administrator shall impose reasonable sanctions as necessary, in its

discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

Disclosure of Certain Enrollment Information to the Plan Sponsor
The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to comply with the above privacy rule provisions.
Pursuant to the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has dis-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor authorizes and directs the Plan, through the Claims Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.
HIPAA has a number of special rules, and the information presented covers only basic points.
If you want to know more about how HIPAA applies to group health plans, the Department of Labor offers a booklet **"Questions and Answers: Recent Changes in Health Care Law."**
You may request this booklet free of charge by calling **(1-800) 998-7542.**
If you are in a Marketplace plan, your eligibility for this medical plan may have an impact on the cost of your Marketplace plan (you may not be eligible for a subsidy for such coverage) if you choose to remain in the Marketplace plan. Contact your Marketplace plan directly for information about your rates and any other questions. If you do not know the contact information, you may find it at www.healthcare.gov or call 1-800-318-2596.

SECTION 18
ERISA RIGHTS

As a Covered Person in the Plan described herein you are entitled to rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Covered Persons shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at all other specified locations, such as work-sites and union halls, all other documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plans' annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of the summary annual report.
4. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of coverage, free of charge, from your group health plan or health insurance issuer on request or when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for Plan Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of Employee Benefit Plans. The people who operate your Plan, called Fiduciaries, have a duty to do so prudently and in the interest of you and other Covered Persons and Dependents. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $120.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a Federal Court.

If it should happen that Plan Fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay the court costs and legal fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

- Please note that Covered Persons and beneficiaries can contact the Department of Labor for assistance or information on their rights under ERISA and HIPAA. You can reach The Department of Labor in New York at 1-212-264-8185.

IMPORTANT HEALTH CARE REFORM NOTICE: CHOICE OF PROVIDER

If your plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, the Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your contact number on the back of your ID card.

If your plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider then you do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your contact number on the back of your ID card.

Amendment and Termination of Plan:

The Plan Sponsor may amend any part or all of the Plan at any time or from time to time or terminate any part or all of the Plan including any benefit component at any time or from time to time.

No person has any contractual right to benefits under the Plan which interferes with the right of the Plan Sponsor to amend or terminate of the Plan. The Plan Sponsor does not make any promise to continue the Plan or any benefits under the Plan in the future and rights to future benefits do not vest.

Signature and Acceptance

The Plan Sponsor as the settlor of the Plan hereby adopts this Plan Document as the written description of the Plan. This document represents both the Plan Document and Summary Plan Description. The Plan Document amends and replaces any prior statement of the health coverage contained in the Plan or any predecessor to the plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed:

Signed: _____

Name: _____

Title: _____

Date: _____

Appendix A

Providence Health Group, LLC.
Employee Benefit Summary – HSA Plan
Network: Cigna PPO
Effective Date: 12/01/2018

Benefit	In-Network	Out-Of-Network
Plan Deductible	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	Embedded
Deductible – INN and OON integration	Deductible amounts accumulate separately for INN and OON	
Member Coinsurance	20%	30%
Out of Pocket Maximum (Inc. Deductible and Coinsurance)	$6,600 Individual / $13,200 Family	$20,000 Individual / $40,000 Family
Out of Pocket – Accumulation	Embedded	Embedded
Out of Pocket – INN and OON integration	Out-of-Pocket amounts accumulate separately for INN and OON	
Annual Benefit Maximum	Unlimited	Unlimited
Lifetime Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	
Medical Services		
Primary Care Physician Office Visits	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Specialist Office Visits	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Maternity	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Chiropractic Care – 25 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Preventive Care – Adult, Infant, Pediatric	No Charge	Deductible and 30% Coinsurance
Lab and Radiology		
Lab and Pathology	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
X-Rays / Radiology (Routine / Diagnostic)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
MRI / MRA; CT / CTA / PET Scan	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Inpatient Services		
Pre-Surgical / Pre-Admission Testing	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Inpatient Physician Services	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Inpatient Mental Health	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Inpatient Rehab – 60 days per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Inpatient Substance Abuse Services	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Outpatient Services		
Outpatient Surgery	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Home Health Care – 100 days per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Hospice – Unlimited	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Mental Health (Includes ABA Therapy)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Second Opinion - Surgical	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Substance Abuse	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance

Therapy Services		
Cardiac Rehab	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Chemotherapy	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Radiation Therapy	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Infusion Therapy (Provider can Buy & Bill)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Occupational Therapy-30 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Physical Therapy - 30 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Physical Rehab - 30 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Respiratory Therapy- 30 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Speech Therapy – 30 visits per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Emergency Services		
Emergency Care	Deductible and 20% Coinsurance	
Urgent Care	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Emergency Medical Transportation	Deductible and 20% Coinsurance	
Other Services		
Allergy Testing	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Durable Medical Equipment (includes Diabetic Supplies)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Orthotics and Prosthetic Devices (1 Wig per Benefit Period Following Chemotherapy; Arch Supports Not Covered)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Dialysis / Hemodialysis	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Home Visits	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Infertility Services (Basic)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Nutritional Counseling - Diabetics	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Nutritional Counseling – Non-Diabetics	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Oral Surgery – Removal of impacted wisdom teeth	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Skilled Nursing Facility – 100 days per benefit period	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Injections (Provider can Buy & Bill)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
TMJ Treatment (appliances not covered)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Hearing Aids (one pair in every 36 Month, up to age 18)	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Transplant Benefits		
Live Donor Health Services	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Bone Marrow Donor Search Fee	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Organ Transplant	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Organ Travel/Lodging	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance
Patient/Donor Travel/Lodging	Deductible and 20% Coinsurance	Deductible and 30% Coinsurance

Prescription Drug Benefits (Magellan Rx: 1-800-424-0472)		
Deductible	Integrated with Medical	
Generic	Deductible and 20% Coinsurance	Deductible and 50% Coinsurance
Brand	Deductible and 20% Coinsurance	Deductible and 50% Coinsurance
Non-Preferred	Deductible and 20% Coinsurance	Deductible and 50% Coinsurance
Specialty Drugs	Deductible and 20% Coinsurance Up to $200 OOP per prescription	Deductible and 50% Coinsurance
90-day Mail Order	Deductible and 20% Coinsurance	Not Covered
Preauthorization (888-721-2128) The following services require Preauthorization, or benefit will be reduced to 50% of the allowed		
Inpatient Services:	**Outpatient Services:**	
Acute Care	**Cochlear Implants**: Osseo integrated, cochlear or auditory brain stem implant	
Maternity routine and high-risk (routine only if inpatient stay exceeds 48/96 federal requirements)	**Diagnostic Radiology**: CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms	
Skilled Nursing Facility	**Durable Medical Equipment**: Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, miscellaneous DME	
Rehabilitation	**Erectile Dysfunction**	
Detox	**Gastric Bypass**	
IP Mental Health and Substance Abuse-Hospital	**Home Health Care**	
	Home Infusion Therapy	
IP Mental Health and Substance Abuse-Residential	**Injectable Medications**	
	Oral Pharynx Procedures	
	Orthotics and Prosthetics	
	Outpatient Procedures: Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty, Vascular surgery	
	Potential experimental/investigational procedures	
	Sleep Management Program	
	Speech Therapy	
	Spinal Procedures	
	Therapeutic Radiology	
	Transplants *Required opt in with Cigna Life Source Transplant Network*	
Exclusions In addition to exclusions listed in the document, the following services are excluded from coverage under the Plan		
Abortion (elective)	Maternity Care for dependent daughters	
Acupuncture	Non-Emergency Care outside the U.S.	
Advanced Infertility Services	Non-Emergency Care in the ER setting	
Bereavement Counseling	Private-Duty Nursing	
Biofeedback	Respite Care	
Cosmetic Surgery	Routine Foot Care	
Dental Care (Routine)	Vision Exam and Hardware	
Long-Term Care	Weight Loss Programs	

Appendix B

Providence Health Group, LLC.
Employee Benefit Summary – PPO Plan
Network: Cigna PPO
Effective Date: 12/01/2018

Benefit	In-Network	Out-Of-Network
Plan Deductible	$2,500 Individual / $7,500 Family	$5,000 Individual / $15,000 Family
Any Other Deductible	N/A	N/A
Deductible – Accumulation	Embedded	Embedded
Deductible – INN and OON integration	Deductible amounts accumulate separately for INN and OON	
Member Coinsurance	30%	50%
Out of Pocket Maximum (Inc. Copay, Deductible and Coinsurance)	$6,600 Individual / $13,200 Family	$13,200 Individual / $26,400 Family
Out of Pocket – Accumulation	Embedded	Embedded
Out of Pocket – INN and OON integration	Out-of-Pocket amounts accumulate separately for INN and OON	
Annual Benefit Maximum	Unlimited	Unlimited
Lifetime Benefit Maximum	Unlimited	Unlimited
Benefit Period	Calendar Year	
Medical Services		
Primary Care Physician Office Visits	$30 Copay	Deductible and 50% Coinsurance
Specialist Office Visits	$60 Copay	Deductible and 50% Coinsurance
Maternity – copay is for 1st Visit only (Hospital stay subject to hospital copay)	$30 Copay	Deductible and 50% Coinsurance
Chiropractic Care	$60 Copay	Deductible and 50% Coinsurance
Preventive Care – Adult, Infant, Pediatric	No Charge	Deductible and 50% Coinsurance
Lab and Radiology		
Lab and Pathology	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
X-Rays / Radiology (Routine / Diagnostic)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
MRI / MRA; CT / CTA / PET Scan	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Inpatient Services		
Pre-Surgical / Pre-Admission Testing	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Hospital Stay: Includes Room and Board; Drugs and Medication; Anesthesia and ICU; Maternity Stay, Inpatient Lab	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Inpatient Physician Services	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Inpatient Mental Health	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Inpatient Rehab – 60 days per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Inpatient Substance Abuse Services	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Outpatient Services		
Outpatient Surgery	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Home Health Care –100 days per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Hospice – Unlimited	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Mental Health (Includes ABA Therapy)	$60 Copay	Deductible and 50% Coinsurance
Second Opinion - Surgical	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance

Substance Abuse	$60 Copay	Deductible and 50% Coinsurance
Therapy Services		
Cardiac Rehab	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Chemotherapy	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Radiation Therapy	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Infusion Therapy (Provider can Buy & Bill)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Occupational Therapy-30 visits per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Physical Therapy - 30 visits per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Physical Rehab - 30 visits per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Respiratory Therapy- 30 visits per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Speech Therapy – 30 visits per benefit period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Emergency Services		
Emergency Care	$250 Copay	
Urgent Care	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Emergency Medical Transportation	Deductible and 30% Coinsurance	
Other Services		
Allergy Testing	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Durable Medical Equipment (includes Diabetic Supplies)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Orthotics and Prosthetic Devices (1 Wig per Benefit Period Following Chemotherapy; Arch Supports Not Covered)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Dialysis / Hemodialysis	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Home Visits	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Infertility Services (Basic)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Nutritional Counseling - Diabetics	$60 Copay	Deductible and 50% Coinsurance
Nutritional Counseling – Non-Diabetics	$60 Copay	Deductible and 50% Coinsurance
Oral Surgery – Removal of impacted wisdom teeth	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Skilled Nursing Facility – Max 100 days per Benefit Period	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Injections (Provider can Buy & Bill)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
TMJ Treatment (appliances not covered)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Hearing Aids (one pair in every 36 Month, up to age 18)	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
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Live Donor Health Services	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Bone Marrow Donor Search Fee	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
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Organ Travel/Lodging	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance
Patient/Donor Travel/Lodging	Deductible and 30% Coinsurance	Deductible and 50% Coinsurance

Prescription Drug Benefits (Magellan Rx: 1-800-424-0472)		
Deductible	N/A	OON Deductible integrated
Generic	$15 Copay	Deductible and 50% Coinsurance
Brand	$30 Copay	Deductible and 50% Coinsurance
Non-Preferred	$45 Copay	Deductible and 50% Coinsurance
Specialty	$75 Copay	Deductible and 50% Coinsurance
90-day Mail Order is available for **2x** co-pay	$30 / $60 / $90	Not Covered
Preauthorization (888-721-2128) The following services require Preauthorization, or benefit will be reduced to 50% of the allowed		
Inpatient Services:	**Outpatient Services:**	
Acute Care	**Cochlear Implants**: Osseo integrated, cochlear or auditory brain stem implant	
Maternity routine and high-risk (routine only if inpatient stay exceeds 48/96 federal requirements)	**Diagnostic Radiology**: CT scans, MRI/MRA, myocardial perfusion imaging, PET scans, cardiac blood pool imaging and cardiac tests including diagnostic cardiac catheterizations and stress echocardiograms	
Skilled Nursing Facility	**Durable Medical Equipment**: Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, miscellaneous DME	
Rehabilitation	**Erectile Dysfunction**	
Detox	**Gastric Bypass**	
IP Mental Health and Substance Abuse-Hospital	**Home Health Care**	
	Home Infusion Therapy	
IP Mental Health and Substance Abuse-Residential	**Injectable Medications**	
	Oral Pharynx Procedures	
	Orthotics and Prosthetics	
	Outpatient Procedures: Facial reconstruction, varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty, Vascular surgery	
	Potential experimental/investigational procedures	
	Sleep Management Program	
	Speech Therapy	
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	Therapeutic Radiology	
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Bereavement Counseling	Private-Duty Nursing	
Biofeedback	Respite Care	
Cosmetic Surgery	Routine Foot Care	
Dental Care (Routine)	Vision Exam and Hardware	
Long-Term Care	Weight Loss Programs	